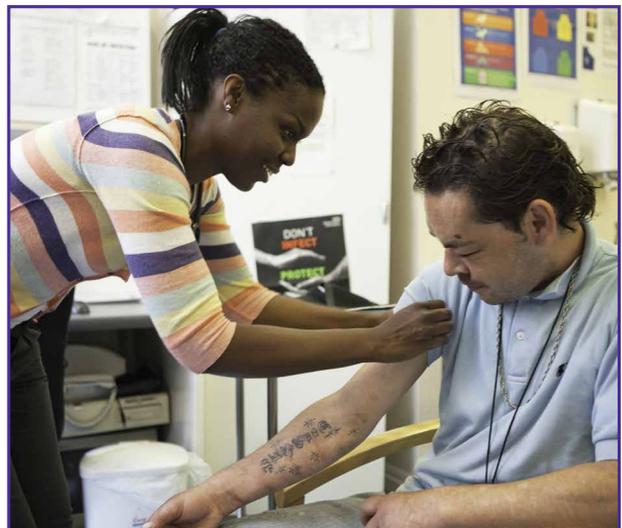
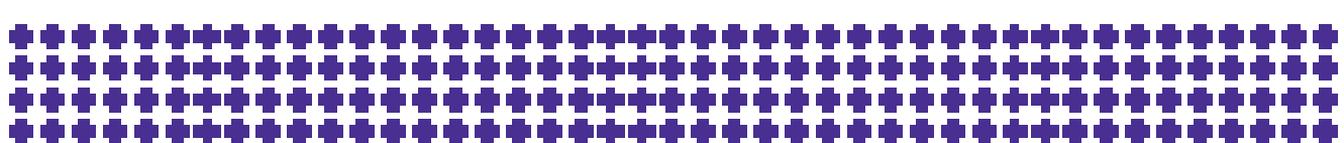


The Fund for Innovation and Leadership

Impact Report 2013-2014



Fund for Innovation and Leadership projects 2013-2014

Since 1990 The Queen's Nursing Institute has supported hundreds of nurse-led projects in England, Wales and Northern Ireland. All projects funded by the QNI are able to take advantage of our highly-rated year-long professional development programme.

The Burdett Trust for Nursing has generously provided funding to enable the QNI to run a two year programme of Innovation and Leadership.

This booklet highlights some of the projects that took place in those two years, from 2013-2014.



‘The difference these plans are already making to the lives of our children and families is amazing. I would like to thank you very much for the opportunity to develop the plans in such a professional manner and with such support.’

Project Lead

Fund for Innovation and Leadership projects 2013-2014

2013:

Project: Anorexia Nervosa Day Programme

Project team: Charlotte Long and Heather Killick
Location: Lincolnshire

Project: Community Cardiac Rehabilitation
Women's Walk Group

Project lead: Sarah Weller
Location: West Yorkshire

Project: Development of a Pathway for
Lymphoedema

Project team: Fiona LeBer and Gilly Glendewar
Location: Jersey, Channel Islands

Project: Dual Diagnostics Physical Health and
Memory Assessment Service

Project lead: Heide Baldwin and Carol Rickaby
Location: Surrey

Project: Exam stress and anxiety management
training

Project team: Jennifer Fong and Julie Bennion
Location: Isle of Man

Project: Health Promotion Clinic

Project team: Shirley McNicholas and Beatrice
Awudu
Location: London

Project: Abdominal Massage in Constipation

Project team: Louise Burton and Debbie
Bromley
Location: Leicestershire

Project: Text4You

Project team: Pat Bowcock and Kathie
Bebbington
Location: East Cheshire

Project: Transferable health resource for the
Gypsy and Traveller community

Project lead: Melissa Kerr
Location: East Sussex

Project: Community Assessment of Risk Tool
(CART)

Project team: Sadie Campbell and Ursula Gray
Location: Northern Ireland

Project: Carer Education Programme to
Support Carers of People at the End of their
Lives

Project team: Kirsty Marshall and Celine Daws
Location: Lancashire

Project: Tailoring Care for Patients with Vascular
Disease

Project team: Esme Elliott and Liz Brittlebank
Location: Newcastle

Project: Falls Prevention for Residential Homes

Project team: Rachel Daly and Jane Edwards
Location: Buckinghamshire

Project: Milk to Meals

Project team: Ros Ratcliffe and Laura Miller
Location: Southampton

Project: Key Stage 1 Early Intervention
Behaviour Management Programme

Project team: Julie Bulmer and Angela
Ladocha
Location: Huddersfield

Project: Catheter Champions

Project lead: Michelle Payne
Location: Northallerton

Project: Improving Early Health Intervention to
Support Residential Care Homes

Project team: Deborah Cheadle and Gillian
Jones
Location: Wales

(In all case studies names have been changed to protect
patient confidentiality.)

2014:

Anorexia Nervosa Day Programme

Project team: Charlotte Long and Heather Killick, Nurse Specialists in Eating Disorders

Location: Lincolnshire

Year: 2013



Summary:

Anorexia Nervosa has the highest mortality rate for any psychiatric condition. Patients who succumb to the disease, do so from either the effects of starvation or by committing suicide. There are no existing services like the Day Programme for people suffering with Anorexia Nervosa in Lincolnshire, nor have there been in the past. The Day Programme will provide the right service for the right people at the right time as recommended in NICE guidelines for eating disorders.

The aim of the project was:

- To improve the physical, psychological and social wellbeing of people with anorexia
- To prevent further deterioration and reduce hospital admissions
- To promote motivation and patient empowerment

Outcomes

- The majority of the participants showed significantly improved Body Mass Index scores.
- Participants reported the ability to eat out socially, something that most of them had previously avoided.
- Very positive patient feedback.

**‘For the first time
in 40 years, I feel I
have really changed
my attitude to food.’
Patient**



Project clients attending a cooking session

Case study:

‘Meg* was a 58 year old lady who had struggled with an eating disorder since the age of 16. Her low weight had resulted in long-term problems with Osteoporosis. Meg had been working with a Nurse Specialist in the Anorexia Nervosa Service, once a week for one hour. Initially she had made some progress, however, this gradually waned and Meg became ‘stuck’. She felt that she needed more than the one hour per week in order to move forward.

We started the Anorexia Nervosa Day programme and Meg attended three focus group meetings. These allowed patients to discuss what they wanted from the day programme and to start planning for individual needs. The programme was held every Monday from 10.30am to 3.30pm and included a mixture of one to one therapeutic interventions and group work. The one to one work included: physical health monitoring, psychological interventions, psycho-social interventions, changing eating habits, body image work, risk assessment, care planning and evaluation. Group work included: psychological work, promoting social well-being, physical health and diet. Meg worked hard to try to make sense of the eating disorder and the role that it played in her life. She contributed well in group discussions and provided support and understanding to others who were experiencing similar difficulties. Meg said that as an older member of the group, she felt a responsibility to be a good role model to others. Meg continues to attend the day programme, which has been increased to three days per week. This arrangement continues to be reviewed every 12 weeks and is dependent upon clinical need. She continues to work hard to address her difficulties and is a positive influence on other members of the group.’

Community Cardiac Rehabilitation Women's Walk Group

Project team: Sarah Weller, Community Cardiac Rehabilitation Nurse

Location: West Yorkshire

Year: 2013



Summary:

Historically women are under-represented in cardiac rehabilitation exercise classes, not just in the Bradford locality but in the United Kingdom as a whole. In Bradford this is a particular problem. According to the British Heart Foundation (BHF) 2012 the national uptake is 42% of all referrals, so as a locality the project was below even the 'unsatisfactory' figures quoted by the BHF.

Some reasons for not participating appear to be specific to ethnic minority groups. Patient Satisfaction Questionnaires revealed that all patients are assessed for suitability for exercise class but amongst those women who declined, most women cited mixed sex classes and transport difficulties as the reason for not accepting a place.

The aim of the project was:

- to improve the physical activity levels of women referred to the Bradford Community Cardiac Rehabilitation Team.

Outcomes

- The project enabled all women referred into the service to access a suitable, safe alternative in order to increase their physical activity.
- **16** women were deemed suitable for the programme and were offered a place.
- **7** women walked with the group regularly and for purposes of the report these were monitored as they could provide consistent results.
- There was a reported increase in the rate of physical activity amongst attendees
- Risk factors were recorded; attendees received education around the ways in which to reduce their individual risk factors for cardio vascular disease.
- Attendees reported a small reduction in anxiety levels around participating in activity.
- An improvement in the Quality of Life indicators (BiPQ) were reported by regular attenders at the group.
- Heart rate and blood pressure measurement showed that most walkers maintained an optimal blood pressure and heart rate prior to and after walking.
- The walk group increased the uptake of exercise by offering a suitable alternative.

‘This project year has been challenging, thought-provoking, frustrating but ultimately very rewarding.’
Project lead

Case study:

‘Mrs A* is 59 years old. She had an extended stay in hospital due to complications after her Coronary Artery Bypass Surgery during which time she lost a lot of confidence and physical strength. Co-morbidities include Diabetes and Hypertension. Mrs A felt that she lacked the confidence to go out by herself and was therefore referred to the Women’s Walk Group. The Brief Illness Perception Questionnaire (BiPQ) revealed that Mrs A felt she lacked understanding of her illness and had no control over her disease. The initial physical assessment revealed she had isolated systolic hypertension and the HAD (Hospital Anxiety and Depression) score revealed significant levels of anxiety. Mrs A was unable to manage a full circuit of the walk at the first session. The next week she was encouraged to warm up and then progress at her own pace. She managed the warm up and a 10 minute walk plus cool down. Mrs A continued to attend the group on a weekly basis and started to complete the circuit with several rests in between. She attended 12 sessions in total and the tests were repeated. The results revealed demonstrated an increase in Mrs A’s understanding of her disease: she now understood that good glycaemic control and a cardio protective diet would have a beneficial impact on her health; she also felt that she had better control over her heart disease. The HAD score was also repeated and Mrs A showed reduced anxiety levels. Mrs A felt she had increased self-confidence and felt that she could venture outside without fear of angina. Mrs A’s daughters felt confident that they could take her out for family walks and Mrs A was now visiting her family in neighbouring streets. She was also planning a trip to Pakistan to see her family.’

A.D.a.M and Ev.E Care Pathway

Project team: Fiona LeBer, QN and Community Sister and Gilly Glendewar, Tissue Viability Nurse Specialist

Location: Jersey, Channel Islands

Year: 2013



Summary:

Lymphoedema is a long term condition that cannot be cured. There are 100,000 people in the UK with Lymphoedema and Chronic Oedema.

According to one report (Lewis 2006), 39% of patients were admitted to hospital with chronic swelling, however only 4 out of 117 were correctly diagnosed with chronic oedema.

£3 billion of NHS budget was used on patients with chronic wounds and Chronic Oedema. The effect of Chronic Oedema and Lymphoedema on a patient is both physical and emotional.

The aim of the project was:

- To improve care given to existing Family Nursing and Home Care patients with lymphoedema and chronic oedema in Jersey

Outcomes

- Developed all relevant documentation.
- Trained **35** members of staff.
- **28** patients placed on Care Pathway.
- All patients had positive outcomes from the new bandaging system and positive feedback from patients.
- **71%** improvement in quality of life from pre-intervention to completion of treatment
- Increase in staff confidence in managing this patient group.

Outputs

- Developed A.D.a.M & Ev.E Care Pathway incorporating assessment tool, algorithm and aide memoire.
- Provided education and training for staff.
- Established local standards of practice for management of conditions.
- Created policy and protocol for management of conditions.

‘My legs have been uncomfortable and swollen for 20 years, and after 2 days in these bandages I can bend my knee and walk again!’ Patient

Case study:

‘Michelle* was a 46 year old lady with recurrent leg ulceration and cellulitis infections. She lived in complicated social circumstances; her 21 year old had a learning disability, her partner had only recently moved back in after a period of separation and her daughter was only 15. Michelle had a number of health problems: morbid obesity, asthma/respiratory problems, anxiety, depression, social isolation and several DVT’s (Deep Vein Thrombosis).

Michelle was on the ‘pending’ list for bariatric surgery which could not be booked until the situation with her legs was resolved. Her left leg was treated first and measured at several key points, a wound assessment chart was completed and photographs taken for a baseline record and to allow accurate comparison of improvement/deterioration.

At the next visit we saw an immediate positive response clinically to the bandaging. Her first set of measurements showed an overall 18cm reduction in size at the set measuring points. Within 2 weeks the volume of exudates had dramatically reduced.

We progressed to both lower limbs having the bandages applied at Michelle’s request. She was so pleased with the results she was seeing, that she felt her goals were now more achievable. Her ulcers had significantly improved. She had begun to socialise again, a friend was visiting weekly to play cards and her trip to the supermarket was more pleasurable due to less pain and her legs were no longer dripping as she walked around the shop.’

Dual Diagnostics Physical Health and Memory Assessment Service

Project team: Heide Baldwin, Mental Health Nurse Consultant and Carol Rickaby, Community Matron for Emergency Care

Location: Surrey

Year: 2013



Summary:

The cost to society of dementia is estimated to be at £19 billion per year, higher than the costs of heart disease, cancer or stroke. According to the Department of Health, only 42% of people with dementia have a formal diagnosis.

An estimated 95% of people with dementia also have one or more long term conditions which may be undetected or poorly managed. A quarter of acute beds are occupied by people with dementia; their length of stay is longer and they are at increased risk of developing further physical illness, or receiving antipsychotic drugs and of admission to long-term care.

Many emergency admissions could be avoided through high quality community management, which this project aimed to provide with the Dual Diagnostic Services.

The aim of the project was:

- Improve detection of Long Term Conditions (LTCs) including dementia
- Reduce use of unscheduled care services
- Increase awareness and understanding of management of LTCs including dementia

Outcomes

- Identified a number of patients who required immediate medical intervention for either poorly managed LTCs or newly detected conditions.
- Local agreement with Alheimers' Society Dementia Navigators to work with patients and families prior to diagnosis to provide continuous support.
- Trained over **200** FCHC (First Community Health & Care) staff in Butterfly Scheme (a system of care for people living with dementia); this is now mandatory training for all FCHC staff.
- Participated in multiple Dementia Awareness events with stakeholders and general public (eg in local shopping centre, community centres, carnivals).
- The new East Surrey Dementia Commissioning Project Plan highlights the project model as a preferred pathway for dementia diagnostics and has been signed off by all major stakeholders (including East Surrey CCG).
- The project lead won a joint research bid with Surrey University to improve the experiences of people with dementia and their carers through staff training and development in FCHC rehab unit (as a direct consequence of the project).

'It has been a major achievement as a mental health nurse, to get support for an area which was previously seen as something to be avoided or ignored.'

Project lead



Exam Stress and Anxiety Management Training

Project team: Jenny Fong, School Nurse

Location: Isle of Man

Year: 2013



Summary:

There has been a year on year increase in referrals to the school mental health nurse for students experiencing anxiety related to exams. Adolescence can be the time when some young people develop mental illness; raising the profile of mental health services within the schools may ease the transition to help for some individuals. 10% of the childhood population has a mental health disorder with 50% of lifetime mental illness being diagnosed by the age of 14.

Prevention and early intervention for young people is more effective than treatment in the latter stages of mental illness. Young people also do better at school when mentally and emotionally well.

The aim of the project was:

- To reduce exam stress and anxiety in a targeted year 10 population
- Improving skills in managing anxiety and stress
- Decreased number of referrals to tier 2 mental health service

Outcomes

- **550** students (Year 10) attended 4 assemblies in 4 schools.
- 5th school which was not originally interested in programme has since requested it.
- **39** students completed the programme.
- **5** out of **6** groups reported significant improvement of their goals.
- Positive feedback from teachers.
- Unexpected outcome: disclosure of additional health needs from students.
- School nursing service lead has requested that the project continue.
- Positive feedback from students.
- Leaflets (below) designed with year 10 students.

'I went from a G to a D because I felt able to ask for help.'
Student



Case study:

'Katy* worked as a teaching assistant. Part of her role was to support children and young people with additional emotional and educational needs. Her hopes for joining the group were to gain skills on how to offer advice and support in managing stress, to bring these skills to students in earlier years in the school and make the group available to other year groups. Katy told me her first impression of the group after session 1 was that it was " brilliant because straight away everyone was able to talk, to say what worries them....everyone pulled together...opened up and expressed themselves."

Katy reported that whilst she did not feel confident to facilitate the group alone she felt more confident working with students around managing stress on an individual level and was more participatory within the group. Katy planned to continue to discuss the project with support staff and was approached by Heads of other year groups for advice on supporting students experiencing exam related stress.

She had fed back her experience of the group to her line manager who gave Katy protected time to co-facilitate the group. The time was for a teaching lesson where the group was run and also teacher preparation time where we planned the session and discussed changes, outcomes and any concerns regarding the students. The project has facilitated joint working between education and health, enabling clearer understanding of roles and enabling young people experiencing stress early access to help and support. Katy has a greater understanding of the impact of stress on young people's health and wellbeing and is able to support students between groups if requested.'

Health Promotion Clinic for Women with Mental Health Problems

Project team: Shirley McNicholas, Women's Lead and Team Manager, Beatrice Awudu, Practice Nurse

Location: Drayton Park Women's Crisis Service, London

Year: 2013



Summary:

The health needs of women with mental health problems can often be neglected. Drayton Park Women's Crisis Service is an alternative to hospital admission for women with mental health problems living in Camden & Islington, London. It has 12 places available at any one time. The service recognises the need for women to have a safe place when in crisis and that, for many women, is a women only environment.

The service works with issues such as childhood sexual abuse and other ongoing abuse issues and a variety of different mental health problems but up till now had lacked a service promoting the importance of good physical health.

The aim of the project was:

The main aim was to improve the physical health of women with mental health problems by providing physical health screening by:

- Increasing uptake to smoking cessation advice
- Increasing uptake of smear tests, and breast screening
- Improving access to information about healthier lifestyle choices such as nutritional advice

Outcomes

- **155** women were seen (some more than once).
- **22** women were referred for smoking cessation.
- **11** women attended cervical smear tests (which were clear).
- **2** women are undergoing a further specialist breast investigation.
- **2** women received treatment for sexually transmitted diseases.
- All women received advice on how to assess their breasts and identify unusual signs.
- **3** women were referred to drug and alcohol services.
- **1** woman was supported with the help of her GP to deal with her addiction to prescription drugs, tramadol and codeine phosphate.

‘Women felt very taken care of by the experience, not exposed or judged, but empowered by information and guidance to take care of their bodies.’

Project lead

Case study:

‘Ms J was referred to the project by her support worker as she was quite manic and yet depressed. Her brother had recently been diagnosed with cancer and she had also received a re-possession order from the council for non-payment of rent on her flat. Ms J had also begun therapy for childhood abuse she had experienced. At the first session, it was noted that she had high blood pressure. She had a thick black rash between her breasts and said she has been using a cream prescribed by her GP but had not seen any improvement. She had not had a cervical smear test in a long time although her last test was abnormal, but she had issues having it done due to the traumatic experiences referenced above. Ms J also reported ‘comfort eating ‘and that she has been craving sugary foods and drinks although knows she has a family history of diabetes. Ms J was reassured that staff at the project would support her to improve her physical health. Her GP was contacted following the assessment and given a full report of all the issues raised. She was offered the next available appointment where her bloods were taken, new treatment for the rash was dispensed, new medication was given to lower her blood pressure, another cervical smear was taken which found abnormal results for which she was referred. We were able to give her advice on healthy eating and gave her access to a healthier diet within the project (as she was a resident), limiting the sugary drinks and boosting her health with fresh fruit and vegetables. She was shown how to check her breasts and given a leaflet with diagrams to help with this. A leaving summary was sent to her GP on her discharge outlining all the above.’

Abdominal Massage in Constipation

Project team: Louise Burton and Debbie Bromley, Specialist Health Visitors

Location: Leicestershire

Year: 2013



Summary:

In the UK, 1.7 million children experience constipation; 70% of disabled children suffer from constipation.

In severe cases, manual evacuation of faeces or surgery may be required, which is particularly distressing to children with disabilities who may have communication difficulties.

Evidence has also shown that individuals with constipation report significantly lower quality of life than those without and those who experience it in childhood, continue to do so throughout their adult life.

The aim of the project was:

- To train parents/carers in abdominal massage to relieve constipation in disabled children
- To improve symptoms associated with constipation
- To improve quality of life for child and family

Outcomes

- **25** sets of parents trained in abdominal massage.
- parents reported:
 - 87.5%** improvement in constipation.
 - 58%** reduction in medication (related to constipation).
 - 37%** reported improvement in sleep.



'I feel equipped with a tool which is more effective than enemas. I know it is effective and I feel in control of Katie's bowel management.'
Patient's mother

Case study:

'Katie* was a severely disabled 17 old girl who was born at 32 weeks gestation. She attended the local area special school on a full time basis. Katie had had a history of constipation from a very early age. Her stools were reported to be Type 6 – 7 on the Bristol Stool Chart, sticky and green in colour, very offensive and passed every two days. Katie experienced abdominal distension and wind regularly. Katie's mother attended the first Abdominal Massage Training Session and the 4 hour session included a presentation on anatomy and physiology, use of the Bristol Stool Chart and "Poo-ometer" measuring tool, advice on toileting and the massage session. At the evaluation session, Katie's mother reported that Katie was passing stools every day that were Type 4 on the Bristol Stool Chart. The colour of the stools were now greeny-brown and less sticky. The abdominal distension, offensive odour and wind had reduced. Katie's mother felt that the use of abdominal massage had improved Katie's constipation and also had reduced the use of medicines and enemas. Later in the year, there was an episode at school when Katie was in intense pain. The education staff believed this was due to a hip dislocation and called Katie's mother asking permission to call an ambulance. Katie's mother advised them to wait until she had seen Katie. When she arrived, she thought Katie may be experiencing abdominal pain. She delivered abdominal massage and Katie became quieter and settled. Once Katie was relaxed, her mum advised education staff that the discomfort was likely to be due to constipation. Later in the afternoon, Katie passed a large stool. Katie continues to receive abdominal massage from her mother and has maintained healthy bowel management.'

Text4Health

Project team: Pat Bowcock and Kathie Bebbington, Deputy Team Leader School Health Nurses
Location: Vale Royal, Cheshire
Year: 2013



Summary:

When a young person has concerns about their health and wellbeing, they often have no means of accessing confidential support and advice. They require a service which will give them a quick and appropriate response.

Young people in Vale Royal knew about the school health service but found it difficult to access a school nurse without having to refer their request through the school receptionist or teacher. School nurse drop-ins are not as accessible as they used to be, so this project aimed to provide a texting service for young people aged 11 to 19 years old.

The aim of the project was:

- To enable and improve communication methods for young people to contact the school health team
- To improve access to an appropriate, timely and confidential health service provision
- To reduce teenage pregnancy/conceptions and increase contraception uptake

Outcomes

- Texting service open since July 2013.
- **364** texts from **72** clients.
- **78** phone calls.
- **29** referrals.
- Good feedback from parents.



'I'm in year 11 and I feel picked on, I want cry and shout all the time I'm having no sleep, and I did try to hang myself last night. PLEASE HELP.'
Student

Case study:

'We received a text from Georgia*. 'I'm in year 11 (15 years old) and I feel really angry and upset all the time. I'm having no sleep and I did try to hang myself last night. PLEASE HELP.' On talking to Georgia we were both reassured that there was no immediate risk of Georgia wanting to harm herself. Kathie met her in school the next morning. She told Kathie she had been having a difficult time lately, she had been in a previous abusive relationship for over a year and her ex-boyfriend was making life very difficult for her. She was subject to verbal racial abuse the previous day and then had had an argument with her mum followed by an argument with her boyfriend. This had all got too much and that is why she had tried to hang herself. Georgia said she had never had previous suicidal thoughts and felt that this was just her reaction to all that had happened during the day. Kathie talked to Georgia about a referral to the Child and Adolescent Mental Health Service (CAMHS) which she agreed to. Kathie explained to Georgia that she would have to tell her mum as she had a duty to safeguard her following her disclosure. She got extremely upset and abusive about this as she did not want Mum to know. Kathie contacted CAMHS and was advised to contact social care and to advise Mum to take her to A&E if she was concerned about self-harming behaviour. Pat maintained telephone contact with both Georgia and Mum over the next few weeks. Georgia was also referred to Quarriers, a young person service that offers intensive support to troubled young people. Georgia did apologise to Kathie a few weeks later and they now have a good relationship. The text service provided an accessible service for Georgia's needs. We hope through this continued support that she will become more resilient and be empowered to deal more effectively with life's emotional stresses.'

Transferable Health Resource for the Gypsy and Traveller Community

Project team: Melissa Kerr, Health Visitor
Location: East Sussex
Year: 2013



Summary:

Travellers - especially those who do not have a permanent address - do not have adequate access to healthcare or public health resources and information. Most contact with professionals is unplanned, at short notice and may only happen once before they move on again.

Currently there is a shortage of appropriate information available for the Gypsy and Traveller community. Ones that are available often use cartoons or stereotyped pictures which can be patronising and disempowering. The project's health resource was developed closely with the Gypsy and Traveller community to ensure that the resources are used, improve health outcomes and reduce client anxiety.

The aim of the project was to design a health resource with travellers, for travellers:

- To improve their understanding of consistent health care
- To improve their access to health care
- To improve health outcomes and reduce inequalities by making health appointments more accessible, increasing the childhood immunisation rates and improving dental care.

Outcomes

- Health resources (leaflets) were created to help the Gypsy/Traveller community access the healthcare services they need and are entitled to.
- The Gypsy/Traveller community has sought out information from resources to access healthcare advice and appointments.
- Local GPs have been accessed more regularly and appropriately.
- Created improved communication and raised awareness of the Gypsy/Traveller community needs and culture amongst healthcare professionals.
- Challenged professional stereotypes and discrimination in an educational and positive way.



**'I don't like saying
I can't read, people
think I'm stupid.'**

Client

Case study:

'Sarah* was housed permanently, had two children under four and lived with her partner, who was not a Traveller. Both parents had learning difficulties and very poor literacy skills. John was recently released from prison after serving a short sentence for burglary. Sarah had local family nearby. As a child, Sarah lived on transit sites with her extended family; she was a non-school attender and witnessed severe domestic violence between her parents.

Over time I built up a productive working relationship with the family and they were very keen to be involved in the project process. During my consultation phase, the family gave varying information on what their needs were. The younger family members were keen for information on contraception and breastfeeding, but the older family members felt that it was against Traveller culture and would cause offence to the extended families.

Sarah was keen to have another child, but her sex education and knowledge was limited. I spent a lot of time explaining the basics around her menstrual cycle and optimum times for conception. I provided health advice, and promoted health services and professionals to the whole family, which was 12 individuals. Sarah became more confident using text messaging and now if she needs anything, she will text me and ask me to call her. I am pleased to say that Sarah is currently pregnant with her third child! I have given her the leaflets about baby ultrasound scans and Midwife appointments and she has stuck them on her fridge; each time she attends an appointment, she crosses one off. I am continuing to see the family regularly; they are proactive now in requesting help and information.'

Community at risk tool (CART) project

Project team: Sadie Campbell, Lead Nurse; Ursula Gray and Angela Conway, Senior Nurse Practitioners

Location: Northern Ireland

Year: 2014



Summary:

Northern Ireland has one of the fastest growing and ageing populations in the UK. It is predicted that the number of people aged 65 and over will increase by 42% from 260,000 to 370,000 in 2025. People are living longer, but often with one or more long-term medical conditions. Advancing age also brings frailty. This project aimed to develop a predictive risk stratification tool (or Community Assessment of Risk Tool, aka CART). Through the use of CART, those patients predicted to be highest at risk of adverse outcomes were offered individualised care pathways. This aimed to decrease hospital admissions because of falls, prevent an increase in patients being admitted to care homes and optimise patients' independence.

The aim of the project was:

- To introduce a risk prediction tool to assess frail patients in the community

Outcomes

- **60** patients were screened and those at high risk were offered tailored interventions on an individual basis.
- An increased number of frail older people who were identified as high risk of frailty were able to be maintained in their own home with increased help and/or support.
- A steering group was created and 3 meetings were attended by healthcare professionals.
- **15** GP practices in the localities of the pilot all received a letter highlighting the project.
- **60** carers were screened for carer strain and **49** reported a medium or high burden of care.
- Carer strain was assessed for all three domains: mental health status, activities of daily living and medical status. The number of Carer's Assessments offered/completed were also collated and the number of onward referrals being made on carers' behalf.

'When I took ill my nurse came and gave me confidence. She helped me in every way from worrying. She keeps my doctor well informed all about me and my needs. When I was ill with a chest infection she got me antibiotics and I didn't have to go to the hospital.'

Client

Case study:

'I received a referral for an 88 year old man for CART screening post hospital discharge. His admission was due to shortness of breath, oedema of his ankles and reduced mobility. He lives with his wife in a rented house. I observed he had a poor inhaler technique and there was evidence of poor medication compliance, for example, he did not understand the preventive aspect of his inhaler management. With a history of gout to fingers in both hands I observed he did not have the dexterity to use a MDI inhaler device. I was able to help the patient choose a more user friendly device to meet his needs.

His wife was very reassured with the service, as she was quickly identified as having carer strain. She now has someone as a point of contact for reassurance and to contact when she has a concern about her husband's health. The proactive management of the long-term conditions and education to both patient and his wife will help manage worsening symptoms earlier and prevent hospital admissions. The client has been very receptive to a host of referrals to help himself and his wife and has become a voice for local residents in the voluntary agency, Agewell, advocating for older people services.

Now when acutely unwell the client and his wife know to request the Case Manager to visit or phone their GP for a home visit. They have a tailored self-management plan to follow and when worsening symptoms become apparent they now know to phone for support. They would not previously have had the confidence to do this and would have waited until the client was in crisis and then phoned an ambulance.'

Carer Education Programme to Support Carers of People at the End of their Lives

Project team: Kirsty Marshall, Clinical Programme Lead My Health My Community and Celine Daws, Community Nursing Team Leader

Location: Lancashire

Year: 2014



Summary:

Informal carers often provide health care support to the person nearing the end of life within a home environment, without any training and support. This can be a daunting experience at a time of great distress. This project aimed to support carers by understanding what their needs are and establish what education they require to better provide this care.

The aims of the project were:

- To improve the individual health care skills of unpaid carers, enabling them to care with compassion and confidence through tailored training courses
- To increase access to evidence-based health information for carers
- To improve carers' knowledge of basic personal care tasks
- To improve the quality of life for patients at the end of their lives.

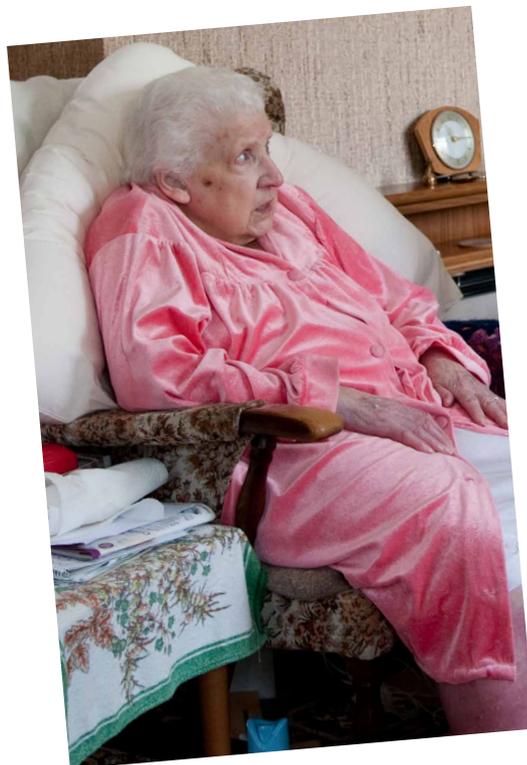
Outcomes

- Courses running and proving popular with carers.
- Community groups booking bespoke training.
- All participants reported increased knowledge and confidence post training.
- The Trust is currently rolling the project out.
- Expansion to provide online educational support.

Outputs

- Educational courses co-designed with carers and third sector partners.
- Delivery of face-to-face skills-based training for carers.
- Promotion of training programme to relevant organisations to help identify informal carers.
- Development of a sustainability package.
- Launch of a supporting website to provide further education and support with a range of resources.

‘The ‘low mood training’ helped me recognise some of the emotions I was having and it gave me some ideas how to deal with them.’
Carer



Tailoring Care for Patients with Vascular Disease

Project team: Sister Esme Elliott and Liz Brittlebank, Practice Manager

Location: Newcastle upon Tyne

Year: 2014



Summary:

The 'SurgeryPod' is in the waiting room and is a touch screen computer terminal attached to scales and a BP machine. There are health check questions pre-programmed to record smoking, alcohol and other lifestyle information. It is available for use at any time during opening hours so frees patients from appointment restrictions.

The 'SurgeryPod' demands a level of self care from patients, as they check their blood pressure themselves. Both qualitative and quantitative evidence demonstrate positive results from improving self care. This has been shown in terms of patient satisfaction, more effective use of the NHS, improved confidence in managing conditions and reduced costs.

The aims of the project were:

- To increase the amount of nurse consultation time to those with vascular disease in greatest need
- To empower patients (with less complex disease) to self-care
- To reduce the amount of nursing time spent on low risk patients

Outcomes

- In the audit group of 30 patients, **6.5** hours of nursing time was saved. This translates to a potential saving of 244 hours of nursing time over the year.
- 38 satisfaction questionnaires were posted, and 19 were returned (a response rate of **50%**).
- Of those who responded, **80%** stated that they were happy to use the pod.
- **198** patients were graded as being at risk level 3 or 4. The neediest group was level 4 which contained 26 patients.
- A large proportion of those with vascular disease are elderly, and there was an assumption amongst nursing and reception staff that to expect those in their 80's and 90's to use the POD was unreasonable. However, many of this client group enjoyed the satisfaction of seeing their results and feeling in control. They also reported that they will use the pod again.

'I like to see the results for myself! – Sometimes if the nurse takes a BP reading you don't get the result. Now I can keep track of my personal records and it reduces the number of times I need to come for personal consultations.'

Client

Case study:

'Mrs T is an 89 year old lady registered as a patient of Wellspring Medical Practice since 2006. At the same time, she was diagnosed with hypertension and chronic kidney disease. Since diagnosis, she has always attended the practice regularly twice each year for a review of these vascular problems – usually to see a nurse but sometimes a doctor. Each annual review would last 20 minutes and the interim review a further 10. In June 2014 Mrs T's records were the subject of a desktop review as part of the QNI project. Mrs T was estimated to be at relatively low risk since her vascular disease is well controlled on just 2 tablets and she understands lifestyle factors and risks very well. She neither smokes nor drinks and is not overweight. At the end of June we therefore wrote to Mrs T to invite her to use our SurgeryPOD to monitor her wellbeing herself.

A couple of weeks later Mrs T came to the practice to try the POD out. She worked her way through all the standard checks, with a bit of help from the receptionist at the desk. Her blood pressure was a little bit high, so she repeated her checks in August and again in September! On this final visit she was more confident and her BP registered 128/68, well within normal limits.

Mrs T tells us she had no concerns about using the POD, but was glad to have the help of a receptionist at her first try. She has seen our explanatory leaflet and thinks it "looks good!" She would be happy to use the POD for any other monitoring which is relevant to her health needs.

Mrs T now saves 30 minutes of nursing time per year by making use of the POD and feels more in control. She can monitor when she wants, at her convenience.'

Falls Prevention for Residential Homes

Project team: Rachel Daly, Quality in Care Team Lead; Jane Edwards, Project Nurse; Liz Hawkes, Assistive Technology Lead; Unoma Okoli, Pharmacist; Ian Williams, data and Julie Collings, Business Support

Location: Buckinghamshire

Year: 2014



Summary:

Despite Telecare technology being used in the community, most care homes are not aware of its existence. Currently the falls service in Buckinghamshire does not cover care homes. This project provided training and awareness on the use of assistive technology in a care home environment to prevent a person from falling and to support individuals who do fall to maintain their independence as safely as possible.

This sometimes isolated world can be brought into the 21st century where technology is part of everyday life and prepares homes for the future generations of care service users.

The aims of the project were:

- To reduce the number and severity of falls in care homes
- To improve quality of life
- To empower the residents, family and providers
- To reduce A&E attendance, hospital admissions and ambulance call outs.

Outcomes

- **22** workshops with the attendance profile of 5 (<2%) residents, 10 relatives and 122 (40%) staff.
- **16** Assistive Technology (AT) assessments were undertaken with 9 AT solutions prescribed and purchased.
- **70%** (220 individuals) had their medicines reviewed with the primary focus being on drugs known to have an effect on falls.
- **600%** increase in requests for AT assessments.
- **45%** reduction in falls related A&E attendance (injurious falls).
- **21%** reduction in self-reported falls (those noted and reported within the care settings).
- Improved consistency in falls reporting.
- **400%** increase in care staff scoring themselves 5/5 from pre to post workshop in skills, knowledge and confidence self-assessments.

‘I now know that I have to be careful when standing up as my blood pressure drops, so I take it easy and steady myself before walking. I tell other residents to do the same as it can prevent them falling.’ Resident



Milk to Meals

Project team: Ros Ratcliffe, Health Visitor and Laura Miller, Community Nursery Nurse
Location: Southampton
Year: 2014



Summary:

One of the most common problems with infant/toddler nutrition in Southampton, is the poor diet of a number of children caused by their excessive intake of milk.

This has been reflected in the reduced health outcomes, including anaemia in young children and levels of obesity in school children.

The increased rate of diabetes and cardiovascular disease in the local adult population can be a long term consequence of poor nutrition in childhood.

The aim of the project was:

- To reduce the incidence of infants/toddlers being given excessive quantities of milk
- To promote awareness amongst parents of the benefits of a healthy solid food diet
- To resolve existing dietary problems amongst children attending café sessions.

Outcomes

- Excellent peer support for parents/carers.
- Café sessions were run to provide support and guidance in relation to weaning/nutrition. Follow up contact in order to reduce milk consumption within a specific group.
- An increased awareness amongst parents was reported of the benefits of a healthy food diet.



‘Because the café sessions were regular and conveniently situated, families started asking to be referred which made us pleased that we initiated the project.’

Project lead

Case study:

‘Ali* was a 3.6 year old Somali boy. Ali only ate sloppy food, mainly milky Weetabix and drank up to 10 cups of diluted fruit juice daily. He was not malnourished or anaemic and his height and weight was on the 25th Centile. His speech was poor and he had been referred to Speech and Language Therapy.

We observed Ali’s Mum giving him lots of attention for not eating. At the first session, Ali lifted the vegetables to his lips, tried them and then started to ‘gag’. At the 2nd session, he was given a thick puree of mixed vegetables. We advised Ali’s mother to sit away from Ali to allow him to eat on his own. After a while he began to touch the food with his hands and lick his fingers. He drank water from a cup but progress was minimal. We gave his mum one of the recipe packs and showed her how to cook the meals. At the 3rd session, to our surprise Ali swallowed a piece of carrot and some yogurt without gagging. His mother was able to tell us that he had eaten a fried egg at home, she had left him to eat it on his own. At the 4th session Ali ate some peas without his mum intervening.

We phoned the family two weeks after, but his mother said there had been no more improvements - he was still being offered sloppy Weetabix. We called them three months later but unfortunately his old eating habits had returned. We offered them a further home visit to offer support but no further attendances occurred.

We felt very disappointed that we were unable to sustain further change for Ali. For the rest of the project we learnt that encouragement, patience and individual advice was the way to help the families that came.’

Key Stage 1 Early Intervention Behaviour Management Programme

Project team: Julie Bulmer and Angela Ladocha, School Nurse Team Leaders

Location: Huddersfield

Year: 2014



Summary:

Challenging behaviour can have a significant negative impact on a child's health and well-being.

Early intervention can improve the behaviour, emotional health and educational attainment of the child as well as improve parenting skills and the relationship between the parent and child.

The existing service that was offered locally by school nurses, was found to be inconsistent, with staff having had little or no training around behaviour support.

The aim of the project was:

- To develop an early intervention pathway that enhances the skills and knowledge of school nurses helping them support parents to manage children with behavioural issues in key stage 1 (ages 4 to 5).

Outcomes

- A pilot group of **10** key stage one families with children aged 4-5 years were supported.
- A pathway was developed based on 3 interventions (see table below).
- **50%** (16) of the School Nurse team received a two-day specialist behaviour training course. These nurses then acted as 'Behaviour Care Pathway Champions'.
- The care pathway will be disseminated to the remaining staff and mainstreamed into the service
- A care pathway framework for School Nursing was developed.
- A reduction in referrals to CAMHS (Children and Adolescent Mental Health Services).



‘Some of the parents had a ‘Eureka moment’ where they recognized that the way they respond to their child has an impact on their behaviour - this was their first step to change.’

Project lead

Case study:

‘Jessica* was 4½ and lived with her mum, dad, baby sister and grandparents in a small house. Jessica’s mum had concerns about Jessica’s behaviour. After discussing Jessica’s home life we discovered that in effect Jessica had four parents all giving her different messages. We discussed realistic expectations given Jessica’s age and discussed the importance of establishing boundaries and teaching children how to manage their emotions. We also gave Mum some literature to support these approaches and a behaviour diary to complete.

At the next review, Mum disclosed that she had suffered with severe postnatal depression after Jessica was born. She had sought treatment and this had led to the family moving in with the grandparents. Whilst her extended family offered her a great deal of support at the time, she realised that it was time for their family to get a house of their own. The family established some ground rules between the adults in the house in terms of parenting Jessica. Mum felt that her mother-in-law had made a huge effort and also felt that she was already seeing improvements in Jessica’s behaviour as a result of this. We set an additional goal for Mum to spend 10 minutes dedicated time with Jessica each day.

At the final review, Mum reported that Jessica’s behaviour was much improved. The boundaries between parents and grandparents were much clearer. Mum had implemented the 10 minutes a day with Jessica by reading to her alone together at bedtime. They also used this time to talk about each other’s days and have a cuddle. Mum and Jessica both really enjoyed this time together. The family are still looking for their own house and are planning on re-submitting their housing application.’

Catheter Champions

Project team: Michelle Payne, Continence Specialist Practitioner

Location: Northallerton

Year: 2014



Summary:

Around 4 million people in the UK have a bladder or bowel control problem. The overall aim of the project was to reduce the usage of indwelling catheters within the community setting, improving the quality of life of patients and reducing the number of catheter acquired urinary tract Infections (CAUTI's). The use of indwelling catheters for the incontinent patient raises their risk of infection by a huge 5% each 24 hours that the catheter remains in situ. In addition the inability to control a basic bodily function such as emptying your bladder without someone's help, erodes an individual's confidence and their social dignity. This project aimed to pilot the use of catheter champions within District Nursing teams to assess every patient with a long term indwelling catheter for their continence needs and to offer alternative continence options that may be more appropriate.

The aim of the project was:

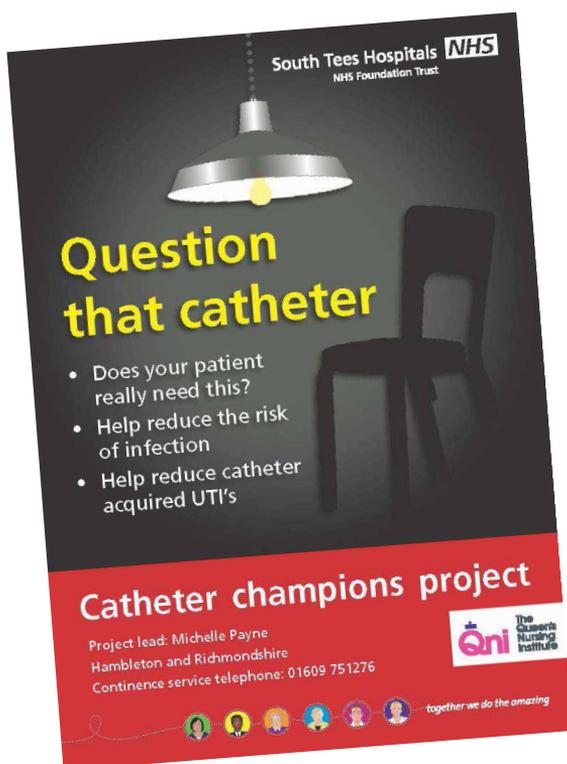
- To develop an expert team member on each District Nursing Team to continue to minimise the usage of indwelling catheters within the Hambleton and Richmondshire locality.

Outcomes

- Each District Nursing team had a minimum of one trained Catheter Champion.
- Out of **243** in-dwelling catheters, **60** were permanently removed.
- Every team in the locality has changed practice and during handover they don't just report 'this catheter has been changed' - the teams give the history and rationale of why that catheter is still in.

'The patient looked more 'alive', she felt more confident with her bladder. She felt as if her life had been given back to her and was so grateful.'

Project lead



Case study:

'Anne* was a 47 year old lady who had contacted us as a last resort. She explained how she had tried to get help over 15 years following the traumatic birth of her only child. The birth had caused her to suffer from urinary incontinence and she had been given a urethral catheter as a means of managing this problem. This was unsuccessful, so she was given a Supra-Pubic catheter. This had also proved problematic; therefore this very desperate lady was having to wear a baby's nappy over the site of her catheter due to it constantly leaking large amounts of urine. There was no doubt that Anne was suffering: she was socially isolated, her marriage had crumbled and she was constantly in pain due to the catheter inside her bladder

The initial assessment revealed that Anne was going to theatre every 8 weeks to have her catheter changed under heavy sedation; due to very powerful bladder muscle spasms she had been told that this was the only means to manage her problem. Anne felt if she asked her consultant, she was labelled an 'awkward' patient. This was confirmed when I spoke to the Consultant Urologist who inferred she was a complainer and that if I wanted to help, I could just 'get on with it' but they wanted nothing more to do with it.

Anne proved extremely easy and quick to teach and learn the skill of self-catheterisation. In one month she had her catheter removed, was performing self-catheterisation 4-5 times daily and her site entrance was healing well. Anne was literally changing before my eyes. She looked more 'alive' and informed me that she had actually gone to church that weekend and this week was meeting a friend for coffee in town; all because she felt more confident with her bladder.'

Improving Early Health Intervention to Support Residential Care Homes

Project team: Deborah Cheadle, District Nurse Team Leader and Gillian Jones, Residential Home Liaison Nurse

Location: Wales

Year: 2014



Summary:

Residential homes are now providing nursing care for patients who frequently have complex needs. The staff within the residential home setting are not trained nurses and require support from the District Nurses to help them care for their clients. This had increased the demand on the District Nursing team for issues that the home could address if given the right support. These issues include tissue viability, continence and catheter care, nutrition and hydration and diabetes management. If a more proactive approach were adopted, the residential homes could be empowered to provide the support they need for their clients. The project aims to support the homes by identifying training and development needs, and assisting them in enhancing their practice.

The aims of the project were:

- To increase the knowledge and skills of care staff within the residential setting
- To decrease the number of same day/ reactive referrals to the District Nursing service
- To reduce the number of clients requiring nursing home care
- To reduce avoidable hospital admissions

Outcomes

- **31%** of staff were trained in Nutrition and Hydration, **41%** in Continence and Catheter care and **45%** in Pressure area Care and First Dressing Initiative.
- Referrals to the District Nursing service within a six month period decreased by **38%**.
- There were no admissions for conditions such as UTI, blocked catheters and falls which are deemed avoidable.
- Phlebotomy training for **7** care staff from the three homes was provided.

**‘You have given me
my life back!’**

Client

Case study:

‘Bob* was a 74 year old gentleman who lived in a care home. Bob needed continence products and wore the one piece type products for severe incontinence changing them two or three times a day. Bob had a very busy social life and loved going out and about. He visited the local public house often, went to his daughter’s house weekly by taxi and he would also go for short walks to the shops. Bob was one of the residents who liked a chat and always appeared cheerful. However, he had started spending a lot of time sitting in his own room and had become more solated due to being banned from the local public house, the taxi firm had refused to collect him anymore and his daughter was struggling to cope with him. This was all due to his incontinence which had become so severe, he would pass large amounts of urine without knowing.

After long consideration about options with both Bob and his GP, it was decided that the best course of action would be to insert an indwelling catheter. Initially Bob continued to wear the continence products as he couldn’t quite trust the fact that he would remain dry, but after a few days support, reassurance and encouragement he was persuaded to stop putting them on.

Six weeks following catheterisation Bob was a different person. He was able to resume his normal life, he was going back to the local public house but his fluid intake was a lot more moderate than previously. He was once again involved in his daughter’s home life, visiting as often as he wanted as the taxi company after reassurance from the home had agreed to let him use them again. He was also able to go shopping to the local centre without fear.’

About the QNI

The Queen's Nursing Institute is a registered charity, founded in 1887, with the original purpose of organising the training and supply of District Nurses on a national basis.

It operates in England, Wales and Northern Ireland, while a separate charity, QNI Scotland, carries out similar purposes there. The charity is incorporated by royal charter and is governed by a board of trustees, who include nurses and other health professionals, and members who have other areas of expertise.

Today the QNI works with all community nurses, not just District Nurses, to improve healthcare for patients in their own homes and communities.

We do this by:

- Funding nurses' own ideas to improve patient care and helping them develop their skills through leadership and training programmes
- Through our national network of Queen's Nurses who are committed to the highest standards of care and who lead and inspire others
- By influencing government, policy makers, and health service planners, and campaigning for resources and investment in high quality community nursing services.

To find out more about the work of the QNI, please visit our website at www.qni.org.uk .





The Queen's Nursing Institute is a registered charity that champions the work of community nurses. Our aim is to ensure that patients receive high quality care where and when they need it, from the right nurse, with the right skills.

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