

**Case study: Improving the proportion of patients not delirious after surgery**  
**Bedford Hospital, Bedford**  
**Dr Sohail Akhtar, consultant**

### Background

Whilst the staff nurses and junior doctors at Bedford Hospital were clearly providing good care to our patients, we wanted to make them more aware of the hip fracture patient care pathway. We believed it would be beneficial for these staff to be trained on how to recognise the early signs of deterioration and delirium. It was evident that there were some communication gaps amongst the staff and that some junior doctors weren't aware of the steps that were to be followed and use of delirium protocol, if they were called during out of normal working hours. The 2018 NHFD annual report showed that in 2018 we were only meeting this KPI for 29% of our patients which we wanted to improve.

### Aim

We aimed to create a friendly environment which enabled and encouraged staff to communicate with one another. Training was also introduced to ensure that the junior doctors and nurses were aware of the hip fracture patient care pathway and felt empowered be able to spot and address the early signs of any change in the patient's condition. We also wanted to address early investigations and management of delirium in our patients.

### Process

Observations of the current ward practice and the plan for improvement was discussed with the Ward Manager and all of the staff nurses, physiotherapist, occupational therapist and medical team.

Daily MDT meetings were put into practice where the steps of the hip fracture patient care pathway were discussed, which raised awareness of the pathway among staff. These were held before the start of ward rounds and led by the ward sister and consultant and included junior doctors, a physiotherapist, a discharge planner and the occupational therapists. Every member of staff attending these meetings were encouraged to actively participate and give their input on the condition of the patient; especially if they had noticed any changes so that the staff can seek to address these during the ward round.

Short teaching sessions were also set in place to make the nurses and junior medical team aware of the hip fracture patient care pathway, which have continued.

Finally, it was also important to make all of the staff involved in care of our hip fracture patients to be motivated through better communication and friendly working relations. Most importantly, an environment was created in which everyone felt able and empowered to raise their concerns about the condition of a patient. Doing so kept everyone informed about all of the outcomes and the progress of the patients under our care.

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## **Outcomes**

We improved our performance in KPI5 from 29% in 2017 to 62% in 2018.

The working relationship amongst the staff was vastly improved which led towards a friendlier environment. The changes made the environment friendlier, making staff members approachable which led to a more cooperative and efficient team. Everyone was made aware about all steps in the management and care of hip fracture patients which, along with the other changes implemented, had a knock on effect of reducing hospital length of stay for our patients.

MDT meetings and its outcomes of improving staff's knowledge and skill levels were well appreciated in other departments where the same practice has now been implemented.

We have also been able to obtain new staff nurses and implement a bed re-configuration.

The process showed that communication is a very important aspect as when it is poor, this can lead to inefficiency, other staff members not being aware of a patient's condition and thus poorer patient care. Motivating staff and encouraging all staff members to take part in the daily MDT meetings by giving their opinions and raising their issues helped them feel empowered which increased their level of patient care.