

The Red Tray Project – Implementation gone wrong...

This is a project that I was involved in over 10 years ago now, when I was very new to implementation. And it is very much a project where implementation went wrong, starting right at the very beginning of the process, we came up with a solution before identifying and understanding the problem. I'll talk you through the project, and what we did, and then I'll back to go through how taking a systematic TRIP approach may have made this project more successful, or prevented us wasting time and effort in poor implementation.

So before this project started, there was a nutrition project in the medical wards which was very successful, and lots of wards talking about wanting to do "protected mealtimes". At the same time, the red tray initiative was being implemented in hospitals throughout the UK, the idea being that patients who need help with eating get their meal delivered on a red tray to flag them with nursing staff. As there was some money left in the project budget at end of financial year, our dietetics dept bought some red trays so that we could test out this idea in our hospital in one of our wards where the dietitian and NUM were keen to improve mealtime care.

The NUM and dietitian got together with the physio and a nurse from the floor, and discussed how they could introduce the red trays. The nurses also complained about the surgeons always interrupting breakfast, and wanted to put in place something to prevent this from happening. The nurses decided on posters displaying meal times with the purpose of preventing interruptions.

Implementing a practice change

- Dietitian developed written protocols for red trays (in consultation with foodservices and NUM)
- Nurse developed and displayed the posters
- Three nursing in-service to talk them through the new processes prior to the launch of red trays

So, what happened after the launch...

On her regular meal time rounds, the dietitian noticed that not all patients who needed feeding assistance were being identified as needing a red tray. In addition, patients with red trays didn't seem to be getting any extra assistance, compared with those with the regular trays. The dietitian reported this to the NUM who said she'd keep reminding her staff.

Not long after implementation, the dietitian rotated workloads and handed the project over to the new dietitian. As you can imagine, it all fizzled out from there...

Reflecting on a poorly executed implementation project is a really good way of learning and appreciating the importance of the AH-TRIP approach to implementation.

If we start with the first step of "identifying the clinical problem", you can see that we went straight for a solution. In healthcare, it's not uncommon that we gravitate towards the "shiny new innovation", and that's what we did in this case – went straight to an innovation that we'd heard about on the grapevine, and that involved a new "thing" to implement (i.e. the shiny new red trays).

AH-TRIP

If we were to take a TRIP approach, we could have started with getting some local data to understand if there was a problem with nutrition and mealtimes on this ward. To get more information, we could have talked to patients and staff from a range of disciplines. This would have all helped us to understand if there was a problem, and if it was an important problem to solve. It would have helped us to understand whose problem it is, how big the problem is, what harm is created by this, and exactly what the problem with mealtimes was and why.

If we had have done this step properly, I expect that we would have found that yes there is a problem with mealtime assistance and interruptions, but that the reason for this isn't nursing staff not knowing who to feed or surgeons not knowing what time breakfast is. Instead I expect the why is a lot more complex than this, but at the time, we didn't know to look at this or use techniques such as asking the 5whys to find the root cause

Getting some data would have also allowed us to measure the impact of our change on mealtime care and experience for patients and staff. If the red trays had been implemented successfully, in this project, we actually had no way of knowing if it had an impact, as we hasn't measured our baseline practice to compare back to.

Identifying the problem was the first and therefore biggest mistake we made in this project. But there were others that could have been prevented by using a TRIP Approach.

Aside from the local evidence from the medical wards, there was actually no evidence to support the interventions we implemented – despite red trays being implemented across NHS trusts, there was no evaluation data available, and data on protected mealtimes was scarce. At the time, the best evidence for managing hospital malnutrition was using high protein and energy diets and oral supplements, so perhaps we might have been better focusing on these strategies.

Reflecting back, using an implementation framework would have been so helpful to guide us through understanding the barriers and enablers to implementing mealtime improvements on this ward. Knowing what I do now about this particular ward, there were a number of barriers present. This ward had a culture that did not embrace change and did not value nutrition, mealtime care was seen by nurses to be a burden, not a valued task, there were some nurses who had strong opinions about nutrition and felt as though they were doing a really good job with this and change wasn't required, again having data to support the change may have had a positive impact. We also should've attempted to think more broadly about our stakeholders and engage the surgeons/ortho geriatric unit, enthusiastic OT, AIN and DAs as part of a working group.

Having a good idea about the problem and the barriers and enablers to change would have meant that we could have had designed an intervention that actually addressed the problem. We could have implemented a solution that directly addresses the problem in a way that overcame barriers, or used enablers to our advantage. We used typical implementation strategies such as inservice and posters, which are unlikely to enough to change something in a complex system like a hospital.

As mentioned previously, without baseline data we had no way of actually evaluating our change, and without tailoring the intervention to the ward and enabling the ward staff to really own and take charge of the implementation, it is not surprising that it all fizzled out once the dietitian rotated out of the ward.

This failed implementation project really demonstrates why identifying a problem is the first step of the TRIP process –IT takes time, and it is second nature to want to jump to the solution and go full steam ahead, but take it from me - failing to identify the right problem in this case resulted in wasted time, effort and change fatigue. So I leave you with the words of John Wooden