IHI Expedition
Smart Use of Resources: Nurses' Time

Session 3: Redesign of Key Processes to Eliminate Waste: Admission process
May 24, 2012

IHI Support Staff

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WebEx Quick Reference

- Welcome to today’s session!
- Please use Chat to “All Participants” for questions
- For technology issues only, please Chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting…

Please send your message to All Participants …NOT All Attendees
Faculty for the Expedition

- Claudia Perez RN, MHI
  Project Lead TCAB, Relationship Based Care
  Seton Healthcare Family, Member Ascension Health
  Austin, Texas

- Mary Viney RN, MSN, CPHQ
  Vice President, Seton Healthcare Family
  Member Ascension Health, Austin, Texas
  Transforming Care at Bedside since 2003.

Overall Goal Of Expedition

AIM:
To provide participants with the content knowledge and skills to enable them to identify and eliminate waste in clinical processes and maximize the time nurses spend in direct patient care.
Overall Objectives of the Expedition
At the end of the expedition will be able to:

1. Recognize the seven categories of waste as they apply to hospital environment
2. Assess work unit for a project to improve the nurses effectiveness and efficiency
3. Use diagnostic tools to study existing processes to identify workarounds and inefficiencies
4. Apply best practices to streamline key processes like admissions, discharge, and medication administration
5. Employ ideas about the use of physical space and placement of supplies and equipment to improve efficiency and reduce wasted movement and time
6. Design a test to increase nurses time spent in direct patient care
7. Describe the linkage between safety and nurses time in direct patient care
8. Theorize about alternative staffing models to more effectively use nursing time and expertise

Session Three Objectives

At the end of this session each participant will be able to:

- Design a review of the current state Admission process (flow chart) to the patient care area
- Design at least one test or trial to reduce waste in the admission process
Today’s Agenda

• Brief review of Session Two
• Hear from colleagues about their activities and learning
  — Geneva “Angel” Hussong
  — Debbie Lowe
  — Shelley Johnson
• Key process – Admission process

Review of the 5S Process

1. **Sort** - All unnecessary equipment and supplies are removed from the area.
2. **Set in Order** - A place for everything and everything is in its place
3. **Shine** - The workplace area is cleaned as the work is performed.
4. **Standardize** - Cleaning and identification methods are consistently applied.
5. **Sustain** - 5S is a habit and is continually improved
Learning from the Action Period

• Review your physical environment and begin to apply the 5S concepts

• Review your current admission process
  — From the patients perspective
  — Documents required
  — How many persons interface with patient from front door to room

Key Processes in Hospital Units

• Admissions
• Transfers In /Out of unit— within the hospital
• Discharges or transitions outside hospital
• Documentation
• Medication management
Admissions

- Depending on your unit, admissions come from varying places and at varying times
- Very few admissions are planned
  - Direct admissions from MD offices
  - Emergency department
  - Post Anesthesia
  - Step down from IMC, ICU
  - Others - Day Surgery, Cath Labs…

TCAB Projects: Admissions

- Admission nurse
- Admission checklist
- Room-ready checklist
- Packets – documentation
- Plan of care stickers
- Fall packet
- Tuck-In orders
- Triage as a process – Not a place
Admissions

- What is planned (reservations)
- What is expected but unplanned
  - Post ops
  - Usually 3 admits from ED
- What is unexpected and unplanned
- Trends by seasons, days of week, time of day can be adjusted by scheduling
- Day to day remains unpredictable

What Must Be Done, by Whom?

- Interview
- Physical assessment
- Review of record
- Regulatory issues (smoking, advanced directives, core measures...more)
- Documentation
- What is duplicative, what adds little value?
Case Study: ThedaCare

Shana Herzfeldt, RN, BSN, Business Unit Manager of Medical Services
Shelia Thiel, MD, Hospitalist Program
Charlotte Gutowski, RPh, Pharmacist
Appleton, Wisconsin

“Hospital of the Future”
Transforming the Patient and Family Experience
Birth of Collaborative Care

• Launched the ThedaCare Improvement System in 2003 (use of Lean concepts and tools as our foundation for continuous improvement initiatives).

• Around 2004 a growing number of leaders, physicians, nurses, pharmacists, and others began voicing the obvious “our current state of patient care was broken”
  ➢ Care was fragmented, inconsistent and not coordinated
  ➢ Resulting in dissatisfaction, confusion, errors
  ➢ Needed to do something that was game-changing
  ➢ Absolute – high integration of our patients/families

• Converged our involvement with TCAB and Lean to develop a new and innovative model of inpatient care

Background

• This transformational initiative was supported by leadership but designed by those doing the work

• Consisted of 18 months of off-line work by a dedicated interdisciplinary team to build the model of care one process at a time

• Opened our 1st Collaborative Care unit on Feb. 19, 2007 at AMC

• Our 2nd unit in June of 2009 at Theda Clark

• Our 3rd unit in July 2010 at AMC

• Spread plan to all Med/Surg units is underway
Essential to the Work

“Voice of the Customer”

“I want to feel that you are all working together. If I don’t feel this, I’m not sure you know what you are doing!”

How we got there.........

Current State Map:

Future State Map:
The Collaborative Care concept evolves

- A vision for clinical care with Nursing being the core

- A new model of inpatient care delivery based on:
  - Change in team roles and responsibilities (**people**)
  - Innovative **processes**
  - Use of **lean** principles of poka-yoke; pull production and visual management

- Provided an **environment** designed to support the model, to reduce waste, to ensure safety and to promote healing.
Collaborative Care Vision

We will create a customer-driven interdisciplinary model of care that reliably delivers exceptional patient outcomes and makes ThedaCare hospitals the inpatient destination of choice for patients and healthcare professionals.

Paradigm Shifts

• A culture and supporting physical environment that promotes cost-effective, reliable patient experiences and outcomes, to meet quality and patient safety goals.

• Roles designed to integrate disciplines into a team that together care for a patient
  – Physician as the medical expert for the team
  – Nurse as coordinator of care progression
  – Pharmacist as clinical expert at the bedside
  – Patient as “Captain of the Ship”

• Development of the professional care team, together learning clinical practice and collaborative processes, that bring accountability for quality improvement to the bedside.
## Strategic Change Processes
### PAST vs. CURRENT

<table>
<thead>
<tr>
<th>KEY ATTRIBUTE</th>
<th>TRADITIONAL MODEL</th>
<th>COLLABORATIVE MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>Disjointed. May be confusing, even contradictory.</td>
<td>Single plan of care developed with patient - is visible, continuously updated with patient driven schedule and goals.</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>Admirable, but not 100% reliable. Manage errors. Nursing maintaining thru herculean efforts</td>
<td>Reliable, standard work, using evidence-based quality and real time problem solving to prevent errors.</td>
</tr>
<tr>
<td>Physician Role</td>
<td>Hierarchical.</td>
<td>Partner in care team. Exposes thinking to professionals team.</td>
</tr>
<tr>
<td>Nursing Role</td>
<td>Task oriented. Too much time spent running for supplies and equipment.</td>
<td>Care manager. Expanded and empowered role in decision making and patient care progression. Bedside management of quality measures</td>
</tr>
<tr>
<td>Environment</td>
<td>Semi-private, dated.</td>
<td>Private. Designed for patient/ staff safety, and to support collaborative processes.</td>
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</tbody>
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## Key Elements of Redesign

- Admission Team
- Tollgates (patented)
- Daily Bedside Care Conferences
- Electronic Medical Record (EMR) supporting one plan of care and links to Milliman Guidelines
- Visual Production Control Management for care progression
- Clarity of all roles to function at their highest scope of practice
- Create a physical environment that promotes safety and key processes that increase care at the bedside
Admission Team

- Done jointly by MD, RN and Pharmacist
- Admission Med Rec by the Pharmacist/extender
- HPI, ROS and Physical exam by MD and Nurse
- Risk screens completed by the nurse and affirmed by the team
- Problem list and Plan of Care determined
- Interventions begun very timely
- Anticipated discharge date discussed

Gains learned so far....

- Tons of duplication for our patients and staff are removed in admission process: repeat questions and processes
- Added in necessary screening tools to improve outcomes, ie DVT, palliative care, smoking cessation, etc.
- Decrease interruptions when you are with another patient, by having the pharmacist involved at the beginning
- Defect-free med reconciliation process with pharmacy involvement
- More meaningful information leaves with patient at time of discharge: example: who to call (next level of accountability), improved medication usage schedule, new folder with how to’s, etc.
The Trio Does Work!!!

Post interviews with the TRIO and patients/families have this to say:

- “This will make me a better doctor” (MD)
- “Having the pharmacist here prevented 4 phone calls for me” (MD)
- “I liked doing this assessment together….I know what you are thinking” (Nursing)
- “This process will help build trust” (referencing the fear that can come with communication in some cases) (Nursing)
- “My knowledge was used when I could influence the care” (Pharmacy)
- “Everyone looked like they knew what they were doing” (Patient/Family)
- Patient in other bed asked “How do I get on that service?” following the TRIO’s departure. (Patient)

Results

- Defect–free admission medication reconciliation by the pharmacist at the bedside!
- Screening tools done on admission to improve outcomes and core quality measures: i.e. CMS bundles, DVT, palliative care, smoking cessation, skin breakdown etc.
- Active use of evidence-based Milliman Guidelines to progress patient care
- Collaboration of patient, core team, and ancillaries built into one plan of care
- Many other positives
Work for Action Period

• Study your admission process (include transfer-in)
  — From patient perspective
  — Documents required, caregivers interacting

• Review your discharge process
  — What will make the transition smooth to next location
  — What are the keys to successfully keeping patient home
Next Call

Redesigning Key Processes to Eliminate Waste: The discharge process

Thursday, June 7, 1:00 – 2:00 PM ET

Stay Connected!

• If you would like additional people to receive session notifications please send their email addresses to improvementmap@ihi.org.
• To use the listserv, address an email to NurseExpedition@ls.ihi.org.