IHI Expedition:
Smart Use of Resources:
Nurses' Time

Session 6 – June 28, 2012

Content: Designing new care delivery models

IHI Support Staff

Tracy Jacobs
Director

Kayla DeVincenitis
Project Coordinator
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

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 participants 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

Today’s Agenda

• Feedback from action period
• Guest to discuss care delivery model and impact on falls and falls harm reduction
• Review emerging challenges, models
• Any questions from previous four sessions
Faculty for the Expedition

- **Annette Bartley** RN, MS, MPH  
  IHI/Health Foundation Fellow  
  Quality Improvement Consultant  
  Lead - Transforming Care at the Bedside in Wales UK

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

Volunteers to Share?

**Action Period Work from Last Webinar:**

- **Review your Medication Administration process**
  - What will make the transition smooth to the next location?
  - What are the keys to successfully keeping the patient home?
Our Guest Presenters

VA Boston Healthcare System

Ellen McCarthy
Kathreen Beals
Lauren Lenihan

Optimized Staffing Models
Ideas of new roles and staffing models

Fall Prevention on A1

Ellen McCarthy, RN
Lauren Lenihan, RN
Katie Beals, RN
A 23 bed acute surgical-telemetry/Rehabilitation floor with 12 subspecialties

- ENT
- Rehab
- Orthopedics
- Plastics
- Urology
- Ophthalmology
- Neurosurgery
- Neurology
- GYN
- General Surgery
- Oral/Dental
- Bariatric

Team Nursing method

Unit is divided into 4 "teams" With two staff per team and one acting as team leader

Either RN or LPN administering medications

Both team members fully responsible for patients and working together to care for the team

Benefits:
- Collaboration amongst staff
- Allowing for the team member not administering medications to have a broader view of the team
- Team could include various combination of staff including RNs, LPNs, and NA.
Daily Assignment

A1 has been a Pioneer in evidence based practice to prevent falls which we have integrated with our TCAB initiatives and continue to update regularly.

In 2009 we introduced:
- The multidisciplinary approach to fall prevention
- The delirium prevention initiative
- Communication boards at the bedside where specialties such as PT/OT can address mobility status

Fall risk indicators were also added at this time. A yellow star is placed on the patient’s clipboard to make staff aware the patient is a fall risk based on the Morse Fall Scale.
“Safety Sweeps”

In February 2011 A1 incorporated “safety sweeps”. Staff assigned to check the rooms every hour. Duties include:

- Scanning the patient environment for safety hazards
- Ensure call lights, phones, TVs, bedside tables and urinals were in reach of the patients.
- Toileting patients if needed
- Setting up and assisting patients with meals
- Offering light snack or refilling drinks if desired

Once a shift we have the patient demonstrates he/she knows how to use the call light.

Studies show that 20% of patients cannot demonstrate use of the call light even after prior demonstration.
Nursing Huddle
At 11:30a and 6:30p nurses on duty report to the nurses station. Each team leader goes over his/her team emphasizing difficult patients, fall risks and need for assistance. Staff are delegated to help out on teams that need extra assistance.

Scheduled dietary need checks

During our safety sweeps and periodically throughout the day staff is assigned to offer nutritious snacks and refreshments. By doing this, staff is able to actively monitor intake and decrease the chance of injury. These checks reduce patients attempting unsafe movement especially post-operatively and in the cognitively impaired population.
Fall Risk Tools

A-1 uses any and all available tools and resources to ensure a safe and comfortable environment for our patients. The floor is always open to new ideas and innovative thinking with priority placed on safety.

Delirium Initiative

Upon arrival to the unit and periodically throughout their stay, patients are screened for risk of delirium. If a risk is identified, patients are watched closely for signs and symptoms and offered resources from our delirium toolbox. Items include reading glasses, stress balls, headphones, sound enhancers, and ear plugs.
**Communication board**

Each patient has an individual communication board at the bedside. The whiteboards are used by the multi-disciplinary team to communicate mobility, dietary restrictions and/or other safety risks. The board is updated as frequently and provides the patient and caregivers vital information to provide quality and safe care.

Staff determine fall risk by using the Morse Fall Scale. If a patient is at risk, a falling star is placed on patient’s chart to alert all staff.

“*The Falling Star*”

### Morse Fall Scale

Fall Risk is based upon Fall Risk Factors and a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete an admission, at change of condition, transfer to a new unit, and after 24 hours.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Score</th>
<th>Admission Date</th>
<th>Review Date</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Falling</td>
<td>No</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>No</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Aid</td>
<td>No</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None/Bedridden//Assist</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crutch/wheelchair</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furnace</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV or E tube</td>
<td>No</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seat</td>
<td>No</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal/bedridden/assisted</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weak</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Status</td>
<td>No</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knows own limits</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overestimates or forgets limits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To obtain the Morse Fall Score add the scores from each category.

<table>
<thead>
<tr>
<th>Morse Fall Score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>45 or higher</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>20-44</td>
</tr>
<tr>
<td>Low Risk</td>
<td>0-24</td>
</tr>
</tbody>
</table>

Note: Complete checklist for resident assessed based on level of risk.
Interventions to Reduce 1:1
A1 uses several methods to decrease the need for 1:1 sitters

Posting "Don't fall! Please call for help if you need to get out of bed" signs at the end of the bed of patients who are impulsive or who have memory issues.

Clip alarms are used when confused patients are out of bed. Bed alarms when they are in bed.
QUICK RESPONSE WHEN THESE ALARMS ARE ACTIVATED

Interventions Continued....

Patients who need close observation are moved closer to the nurses’ station and assigned to rooms in close proximity if possible.

Engaging patients as much as possible using nursing staff, recreation staff and delirium prevention staff.

When all else fails then we use a 1 to 1 sitter
**Falls in Ward A1 (Oct. 2010-Mar 2012) and Tests of Change Implemented**

Key points:

- The chart demonstrated decreased falls starting in January 2011 after implementing several initiatives.
- There was an increase in falls from July to September 2011, but remained below the benchmark for injuries. The fluctuation was evaluated and determined to involve amputee patients.
- A learning deficit was identified and staff teaching was initiated regarding this specific patient population. A significant decrease in falls was noticed.
Summary

- Implementing and maintaining fall prevention initiatives is an ongoing process that A1 is committed to with focus on patient safety.
- New initiatives include, nursing huddles, safety sweeps, fall risk indicators, communications boards, and delirium prevention initiative.

REMEMBER...

Patient safety is everyone’s responsibility
The Future of Nursing

Institute of Medicine report (2011) - One key message:

• Nurses should practice to the full extent of their education and training
• Registered Nurses should be investing time on those elements which impact patient outcomes
Future of Nursing

• As nurses reach to the full scope of their role so also will the team working alongside nurses
  • Pharmacy Technicians
    • Medication reconciliation
    • Coordinating, preparing 0900 medications
    • Assuring par levels are available, stocked
    • Expediting first doses, new admission medications

Innovative Care Models

[Diagram showing Acute Care, Bridge Continuum, and Comprehensive Care]
Acute Care

- Care Team Model (Seton)
  - Every patient deserves an experienced nurse
  - Every new nurse deserves an experienced nurse
    - Assignments are made with Experienced Nurse on same team as new graduate
- Admission Nurse for 5-6 hours / day
- Discharge Nurse for complex patients

Acuity-based Staffing

- Example from Vanderbilt Medical Center (2009)
- 36 bed OB/GYN
  - High patient turnover
  - Nurses overwhelmed; patients dissatisfied
- Changed staffing model to match patient acuity
  - Flex up or down as acuity demands
  - Charge nurse recalculates acuity every two hours and adjusts accordingly
- After 2 years…
  - Nurse turnover decreased
  - Patient satisfaction increased
Changing Locations

• Adding a Med-Surg Nurse to Emergency department to start admission orders while waiting for a bed
• Placing a Diabetes Educator in Emergency department to quickly identify patients with diabetes and stabilize with next day office appointment rather than admission to hospital

Bridge Continuum

• Nurse Navigator Roles
  • RNs who help transition patients from inpatient care to home
  • Check in after discharge after overnight
  • Prescriptions filled
  • Post hospital MD appointment
  • Answers questions about instructions for care
Physical Therapy/Nursing Aides

- Additional training in safe transfers, mobilizing patients
- Help mobilize patient, implement plan of care
- Teach crutch walking, transfer skills

Health Coaches

- Lay persons with extra training to support patients in home setting
- Often can follow the patient home
- Help support life style changes
  - Smoking, nutrition, movement
  - Not yet reimbursed, but some companies are investing to reduce risks of covered lives
Comprehensive Care

- Telehealth, Telemedicine: Videos
  - Can any services be supported remotely?
    - Centralized video monitoring instead of sitters?
  - Critical Care Nurse to assess unstable Med-Surg patient
  - Behavioral Health consult with APRN to support unit staff

Summary

AIM of this expedition was:
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.
Session One Objectives

• Introduce the expedition team/faculty
• Provide some background and context for the work
• Describe how to undertake a diagnostic to uncover waste – using time sampling and observation
• How to assess their work unit for a project to improve the nurses effectiveness
• Provide an overview of the Model for Improvement
• Helps teams to design a test to increase nurses time spent in direct care

Session Two Objectives

At the end of the session each participant will be able to:
• Streamline and standardize supplies and equipment throughout the unit
• Relocate essential supplies and equipment near or in patients’ rooms
Session Three Objectives

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

• Design a review of the current state of your admission process (flow chart) to the patient care area
• Design at least one test or trial to reduce waste in the admission process

Session Four Objectives

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

• Design a review of the current state of your discharge process (flow chart) to the patient care area
• Design at least one test or trial to reduce waste in the discharge process
Session Five Objectives

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

• Explore your medication systems
  — From the patient experience
  — Handovers of care
    ➢ Within hospitals
    ➢ To and from community
• Flow chart from time medications are ordered to when patient receives

Session Six Objectives

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

• Review possible changes to current care delivery models
Improvement Requires a Clear Aim

Measurement & Action

The Steps To Change

- Prerequisites for change
- Prototype a change
- Test under a variety of conditions
- Embed in daily operations
- Implement a change
- Spread throughout the system

Confidence that change is effective
Let’s Hear From You

• Questions regarding any of the work to date?

Volunteers:
• Debbie Lowe
• Lorraine Frank-Lightfoot

Guest Presenters from VA Boston
• Ellen McCarthy
• Kathreen Beals
• Lauren Lenihan

Thanks to our Volunteers and Guest Presenters!
To conclude

• “Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around”

• Leo Buscaglia

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.
Follow up

• A manual with instructions to receive Continuing Education Credits will be sent with the follow-up email for today's session.

• Please take 5 minutes to complete the Expedition evaluation survey.

References

• www.innovativecaremodels.com