IHCA Nurse Manager Training

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QUALIS HEALTH
Advancing Healthcare
Improving Health

Clinical Quality Care

- Module 8 – self study discussion
  - Theories of Aging
  - Aging Process
  - Altered Physiological Responses in the elderly
  - Impact of institutionalizing the elderly
  - Nursing management for challenging conditions
  - Special needs of the cognitively impaired
  - Models of Care

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Quality Improvement Program Basics

- Select teams, set aims
- Define measures
- Identify opportunities for improvement
  - Gap analysis
- Conduct small tests of change
  - Plan/Do/Study/Act (PDSA)
- Change management system
  - Sustainability
  - Spread

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Beyond the Basics

- Event investigation and root cause analysis
- System redesign vs behavior change
- Five elements of QAPI
  - Design and scope
  - Governance and leadership
  - Feedback, data systems, monitoring
  - Process improvement projects
  - Systematic analysis and systemic action

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Quality Improvement Program Basics

Setting Aims

- Time-specific and measurable
- Define the specific population of patients that will be affected
  - Reduce pressure ulcer of rate of long-stay high-risk residents by 20% by November 2012
  - Eliminate all unnecessary physical restraints among long-stay residents to achieve 3% rate by November 2012

Forming a Team

- Review the aim
- What system will be impacted by improvements?
- Include members familiar with all parts of the process
- Identify an executive sponsor who takes responsibility for the success of the project

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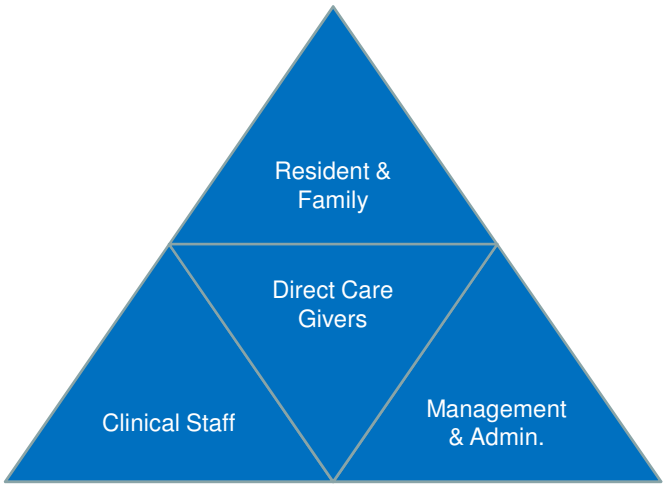
Susan Eaton Team Model



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Effective Teams

- Clinical Leader (system leadership)
- Technical Expertise
- Day-to-Day Leadership

- Executive Sponsor

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Informal Meetings

- Purpose: Regain situational awareness
  - Briefs: planning
  - Debriefs: process improvement
  - Huddles: problem solving

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Measurement for Improvement

- Why?
  - Connects your aim with a measurable goal
  - Helps determine if changes are leading to improvement
- Best practice:
  - Measure a baseline (starting point)
  - Collect "just enough" data using current work flow
  - Keep method consistent over time
  - Always define population and time period


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Three Types of Measures

- Outcome measures
  - *Are we achieving the desired result?*
  - Example: Percent of long-stay high-risk residents with pressure ulcers
  - Example: Percent of long-stay residents with daily physical restraints


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Three Types of Measures

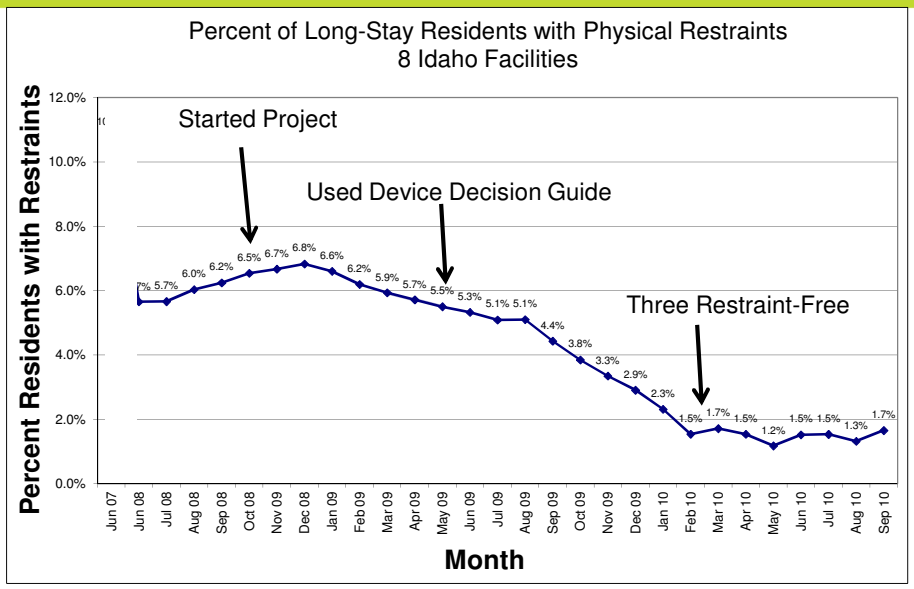
- Process measures
  - *How we get the result (interventions/actions)?*
  - Example: % high-risk residents with effective pressure-relieving surfaces
  - Example: % residents with daily physical restraint use evaluated by therapist quarterly

Types of Measures

- Balancing measures
  - Measure potentially unexpected effects
  - Example: Percent of aides reporting improved job satisfaction
  - Example: Number of falls resulting in injury per quarter

http://www.qualishealthmedicare.org/about-us/results/local-success-stories/caldwell-care-center

Run Chart



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Discussion: Measurement

- What ideas do you have for outcome, process, and balancing measures?
- How can you automate or use data already easily available?

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Select Changes to Test

- Baseline measurement
- Assessment tools
- Gap Analysis
  - Where does your current system breakdown?
  - Is there an evidence-based tool?
  - Do a root cause analysis of your last resident fall/ new in-house pressure ulcer

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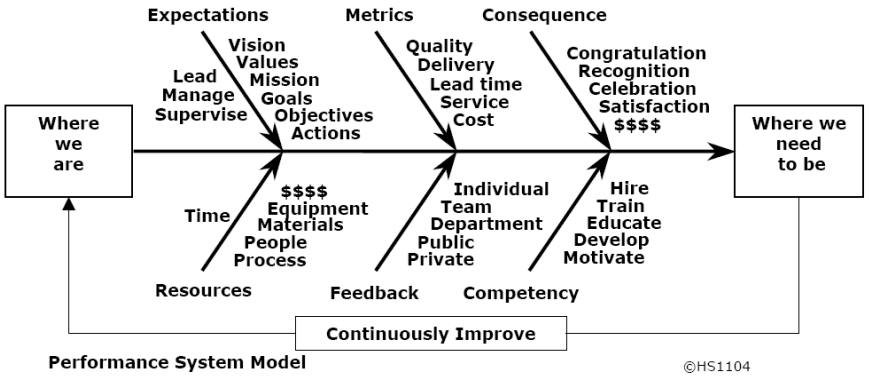
Six-Factors for Human Performance



Howard Sommerfeld

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Characteristics of the Change

- Specific action
- Multiple possible approaches
- Matches a gap in your current system
- Easy to try out – test of one
- Results immediately/quickly observable
- Simple and concrete
- Consider cost, time, and resources

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PDSA
Plan-Do-Study-Act

- Method for testing and making change
- Guides critical thinking

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Pilot Test

- PDSA tests are small and quick
  - One shift
  - One person
  - One time
- Apply learning and repeat
  - Adapt change and try again
  - Spread tests to a new person, shift, unit
  - Continue to modify test until successful


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IHI Model for Improvement

1. What are we trying to accomplish?
2. How will we know that a change is an improvement? *
3. What changes can we make that will result in improvement?

* All improvement involves change, but not all change is improvement


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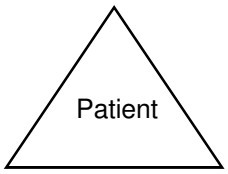
Sustaining Change

Effective Leadership
Leading Change
Changing Systems and Structures



Human Factors
Staff Commitment

Reliable Processes
Standardize practice

3 elements of patient safety triangle adapted from www.IHI.org

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A Good Change Management Model

Leading Change
1. Creating a shared need
2. Shaping a vision
3. Mobilizing commitment

Staff Commitment

4. Making change last
5. Monitoring progress

Changing systems and structures

Sustaining Change

GE Change Acceleration Process (CAP) Model

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Leadership at Every Step

Leading Change

- How can we be most effective in leading?
- Having a champion who sponsors the change. Leadership provides the time, passion and focus for the effort.

Changing Systems and Structures

- What organizational structures can we put in place to sustain the changes?
- Hiring & staffing, IT systems, training & development, resource allocation, redefine job descriptions, policies & procedures


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Think it Through

1. Creating a shared need
   - Why do we need to change?
2. Shaping a vision
   - Do we have a clear vision of the future state?
3. Mobilizing commitment
   - How can we get everyone on board?

Small tests of change with forgiving partners, work out kinks, **learn**, adapt to local environment.


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Think It Through

4. Making change last
   - What could propel or impede our changes?
5. Monitoring progress
   - How will we measure success?

Our Best Tips for Sustainability

- Agree what exactly you are trying to sustain
  - The specific change
  - The underlying culture
  - The measured outcome of the change
  - A combination of these

Our Best Tips for Sustainability

- Clear benefit to all stakeholders
  - Involved staff, residents, family, other health care partners, regulators

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Our Best Tips for Sustainability

- Small tests of change (pilots)
  - What change idea are we testing?
  - What are we trying to accomplish?
  - How will we know when a change is an improvement?

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Our Best Tips for Sustainability

- Update your training system
  - Coach on the floor during actual work
  - Respond to barriers as they arise
  - New job descriptions for staff development, managers, supervisors

More ideas in reference 3. Improvement Leader's Guide to Sustainability and Spread, UK's National Health Service Mod Agency

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Beyond the Basics

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Five Guidelines for Improved Event Investigation

- Causal statements should show the cause and effect
- Negative descriptors may not be used—instead ask "why" again and find a more descriptive and actionable root cause
- Each human error should have a preceding cause
- Each procedural deviation should have a preceding cause
- Failure to act is only causal when there was a pre-existing duty to act

David Marx

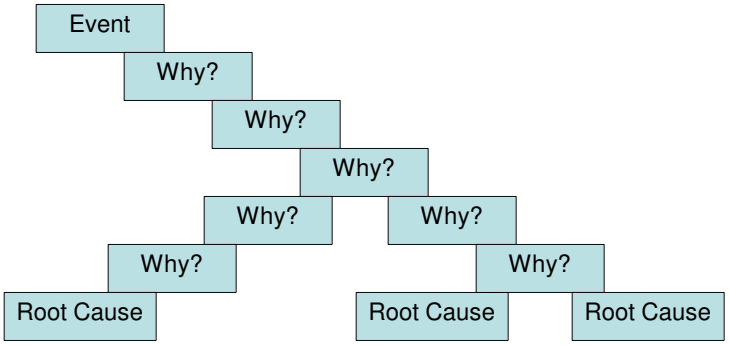
Basics of Event Investigation

3 Questions:

- What happened?
- Why did it happen?
- How were we managing it?

David Marx

5 Whys Method



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Two Types of Causes

- System Design
  - Process
  - "the way we do things here"
  - Access to resources and information
- Behavior Choices
  - Variation by individual
  - Given the information present at the time

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Case Study One

- Fall
- Why? She fainted
- Why? She had low blood sugar
- Why? Recent sliding scale insulin dose too high
- Why? Nurse failed to calculate correctly
- Why? Nurse was interrupted during process and did not have a second nurse double check dose

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What Next?

- How were we managing the risk?
  - Review System Design
  - Review Behavioral Choices

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Review System Design

- Why do you allow sliding-scale insulin orders in the first place?
- What is your policy for safe med pass?
- Are you relying on competency alone?
- What barriers, redundancies and recovery methods can you put in place to prevent errors in the future?
- What systems can you put in place to decrease interruptions during med pass?

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Review Behavioral Choices

- What processes do other nurses in the same situation use to reduce risk of error?
- Was this nurse aware of the level of risk?
- What conflicting priorities were present?
- Would training or coaching be more effective in this case?

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Case Study Two

- New stage 1 pressure ulcer found on heel
- Why? Pressure to heel when immobile in bed
- Why? Weakness and weight of bedding make it too hard to re-position self
- Why? Recovering from illness and not eating
- Why? Food is not appetizing
- Why? Doesn't want to eat at the time meal is served and at temperature—sufficient snacks / alternatives not available

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What Next?

- How were we managing the risk?
  - Review System Design
  - Review Behavioral Choices

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Review System Design

- Take look at the mattress & bedding—what about a blanket bar?
- What about restorative or physical therapy for strengthening?
- What alternatives can you make available for nutrition?
- What would it take to make hot food available at any time?
- What does this person most like to eat?


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Review Behavioral Choices

- What policies/procedure/practices are expected for repositioning?
- What is the cultural norm among other caregivers on the same unit?
- What conflicting priorities were present?
- Would training or coaching be more effective in this case?


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Behavior Types and Responses

Behavior Type	Best Leader Response
Human Error	Console and look at system
At-risk Behavior	Coach to raise awareness
Reckless Behavior	Consequences

David Marx

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Quality Improvement Programs in Nursing Homes

- Current federal requirements:
  - QA&A Interdisciplinary teams meet quarterly
  - Evaluate deficiencies
  - Create action plans
- We deserve (and commonly do) better!
- New federal requirements
  - QAPI (Quality Assurance/Process Improvement = Quality Improvement Program)
  - National rollout 2013 ?

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Five Elements of QAPI

- Design and scope
- Governance and leadership
- Feedback, data systems, monitoring
- Process improvement projects
- Systematic analysis and systemic action
  - Root cause analysis
  - System focus

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Resources

- IHI Knowledge Center / Model for Improvement http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx
- GE Health Care Performance Solutions: Change Acceleration Process (CAP) http://www.gehealthcare.com/usen/service/performance_solutions/docs/CAP_And_Workout.pdf
- GE CAP blog (simplified) http://bvonderlinn.wordpress.com/2009/01/25/overview-of-ges-change-acceleration-process-cap/

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Resources

- Improvement Leader's Guide to Sustainability and Spread, UK's National Health Service Mod Agency http://www.fundacionpfizer.org/docs/pdf/catedra_pfizer/servicios_on_line/enlaces/difusionsostenibilidad.pdf
- David Marx http://www.justculture.org
- QAPI https://www.cms.gov/SurveyCertificationGenInfo/05_QAPI.asp
- MDS 3.0 QM Trend reports

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