Reaching the Core of Quality

7th Annual American Nurses Association Nursing Quality Conference
February 2013

Session 211: Engaging the Bedside Nurse in Quality Improvement

Presented by: Holli Roberts, MSN, RN
Nursing Quality Coordinator
Objectives

• Describe a methodology to analyze and display unit specific nurse sensitive clinical indicators
• Examine a tactic to engage bedside staff in quality improvement and patient safety
• Apply a process that improves staff nurse understanding and accountability for clinical outcomes

Serving Louisville, Kentucky, and surrounding areas.
Baptist Healthcare System

- Seven owned and two managed hospitals
- One long term care and one HMO
- Thirteen primary care centers
- Five foundations
- Two home health agencies
- Eighteen clinics at Wal-Mart
- Nine urgent care centers
- Nine physical therapy/sports medicine centers
- Three fitness centers
- Fifteen occupational health centers
- 53 Physician offices
- Three psychiatric units
- Two rehabilitation centers
- Two PET/CT centers
- Five OP radiation therapy centers
Mission Statement

- Exemplify our Christian heritage of service of providing quality healthcare services by enhancing the health of the people and communities we serve.

A Culture of Excellence

- Magnet Recognized
- American Nurses Foundation
- Best Places to Work
- Thomson Reuters: 50 Top Community Hospitals
- start!
The “core” of nursing at BHE is represented in the Professional Practice Model.

**Background**

- Magnet components EP 32EO and OO 23
- Organization should outperform the mean of a national database
- Provide analysis and evaluation of data related to patient falls, HAPU and 2 of the following: CLABSI, CAUTI, VAP, restraints, PIV and other specialty-specific indicators
Goals

• Monitor nurse sensitive indicators (NSI) on all nursing units
• Develop a consistent process to showcase NSI with frontline staff
• Increase staff awareness, involvement and accountability in performance improvement

Donabedian’s Theory

• Donabedian identifies three objects in quality improvement

[Diagram]

• A complete quality assessment program requires the simultaneous use of all three
The Blossom

**Structure:**
Develop a Nurse Sensitive Indicator (NSI) for every unit

**Population Specific NSI**

- **National**
  - NDNQI - Falls, HAPU, Restraints
  - NHSN - CAUTI, CLABSI, VAP
  - Core measures - SCIP, AMI, PN
- **Other**
  - National initiatives - Premier, Press Ganey
  - State or local initiatives
- **Hospital goals**
**The Tree**

**Structure:**
NSI on every unit

**Process:**
Develop a strategy to address NSI

**Major Stakeholders**

- **Departments and Committees**
- **Patients**
- **Bedside Nurses**
- **Leaders**

**Shared Governance**

- Ops
- Research
- Education
- Practice
- Quality
- UBSG
- Ns Council
Considerations

• Research shows engaging staff at the point of care leads to sustained improvements
  – Patients are impacted by the actions of staff
• Actions may vary from unit to unit due to unique:
  – Staff relationships
  – Practice environments
  – Patient populations
  – Skill mix

Major Stakeholders

Shared Governance

Unit Based Shared Governance

Quality Council Representatives
SUPPORT and EMPOWER staff nurses in using empirical data to govern quality improvement at the unit level.

Process:
Develop a strategy to address NSI

Showcase results
Design a Template

- Incorporate the hospital’s quality model for performance improvement
- All inclusive repository to chronicle performance with actions

Outcomes Report Template

NURSE SENSITIVE INDICATOR/ OUTCOME: Falls

<table>
<thead>
<tr>
<th>Nurse sensitive indicator / outcome: Falls - defined as the total number of falls on your unit divided your patient volume. The goal is to be below the National Database of Nursing Quality Indicators (NDNQI) benchmark.</th>
</tr>
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</table>

<table>
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<tr>
<th>PLAN (Goal):</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSE SENSITIVE INDICATOR/ OUTCOME: Falls</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Falls per 1000 patient adjusted days: 6North</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls Rate</td>
</tr>
<tr>
<td>2010</td>
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<tr>
<td>B North</td>
</tr>
<tr>
<td>NDNQI</td>
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<table>
<thead>
<tr>
<th>DO (Interventions):</th>
</tr>
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<tr>
<td>Use bed alarm for patients at falls risk</td>
</tr>
<tr>
<td>Encourage gait belt use, Stocked and assigned to NAT</td>
</tr>
<tr>
<td>Falls prevention is a yearly competency</td>
</tr>
<tr>
<td>Falls Huddles</td>
</tr>
<tr>
<td>Place “Call, don’t fall” signs in Bathrooms to alert patient to use pull string for staff to assist them</td>
</tr>
<tr>
<td>Place bed check &amp; falls stickers on Kardex</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHECK (Analysis) / ACT (Revisions):</th>
</tr>
</thead>
<tbody>
<tr>
<td>3Q 2010 Numbers increased but are still in desired range.</td>
</tr>
<tr>
<td>1Q 2011 4 Falls, continue interventions, add running log in 2wQ</td>
</tr>
<tr>
<td>3Q 2011 Great improvement, continue interventions.</td>
</tr>
</tbody>
</table>

| 4Q 2010 Numbers decreased, continue interventions |
| 2Q 2011 Incidence increased, continue interventions, see 3Q interventions. |
| 4Q 2011 slightly below NDNQI benchmark (see 4/12 interventions) continue to monitor |
| 1Q 2012 improved, continue to monitor |
| 2Q 2012 |

BAPTIST HEALTH
Bulletin Board Field Trip

OUTCOMES

Process:
Develop a strategy to address NSI

Manage and analyze data
Showcase results
Data Analysis

NURSE SENSITIVE INDICATOR/OUTCOME: Falls

PLAN (Goal):

Nurse sensitive indicator/outcome: Falls - defined as the total number of falls on your unit divided by your patient volume.

The goal is to be below the National Database of Nursing Quality Indicators (NDNQI) benchmark.

<table>
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<tr>
<th>Falls Rate</th>
<th>3Q10</th>
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<th>2Q11</th>
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<th>4Q11</th>
<th>1Q12</th>
<th>2Q12</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>3.41</td>
<td>1.85</td>
<td>1.78</td>
<td>4.81</td>
<td>1.92</td>
<td>3.42</td>
<td>1.99</td>
<td>6.03</td>
</tr>
<tr>
<td>NDNQI</td>
<td>3.55</td>
<td>3.52</td>
<td>3.45</td>
<td>3.43</td>
<td>3.51</td>
<td>3.58</td>
<td>3.35</td>
<td>3.48</td>
</tr>
</tbody>
</table>

DO (Interventions):

- Use bed alarm for patients at falls risk
- Encourage gait belt use. Stocked and assigned to NAT
- Falls prevention is a yearly competency
- Falls Huddles
- Place "Call, don't fall" signs in Bathrooms to alert patient to use pull string for staff to assist them
- Place bed check & falls stickers on Kardex

3Q 2010 Numbers increased but are still in desired range. 4Q 2010 Numbers decreased, continue interventions
1Q 2011 4 Falls, continue interventions, add running log in 2ndQ
3Q 2011 Great improvement, continue interventions.
1Q 2012 Improved, continue to monitor

CHECK (Analysis) / ACT (Revisions):

3Q 2010 Numbers increased but are still in desired range. 4Q 2010 Numbers decreased, continue interventions
2Q 11- Unit implemented a running log on pt satisfaction board: "No falls since___" running log
9-11- "Bed alarm in use Please Reactivate" signs for beds 9-11
10-11- Trending Falls data to correlate with time of day falls occur
10-11- Tip of the month regarding using gait belts & Bed Alarm in Use signs
4/12 made more bed alarm signs

3Q 2011 Great improvement, continue interventions.
4Q 2011 slightly below NDNQI benchmark (see 4/12 interventions) continue to monitor

Process: Develop a strategy to address NSI
Present, discuss and develop action plans
Manage and analyze data
Showcase results
Data Management

- Quality representatives attend unit based shared governance (UBSG) team meetings to present quarterly data
- Discuss each NSI as a team
  - Bump versus a trend
  - Other practice concerns
- Develop actions for improvement
- Update report
  - Saved in a common folder for sharing

Process:
Develop a strategy to address NSI

Implement initiatives
- Present, discuss and develop action plans
- Manage and analyze data
- Showcase results

BAPTIST HEALTH
Unit Level Initiatives

• Examples of unit projects to improve care
  – “I Will” …binder (6 South)
  – Falls pamphlet (6 Park and Rehab)
  – Education cards (Ambulatory Care Unit)
  – Highlighting medication education (Phase II Recovery)
  – SCIP team (Peri-op units)
  – Generalized projects

“I Will”… Binder

• Each person commits to a way they would help improve a specific care issue
• Statements are placed in a binder and displayed in a common area
• Reminders to remain focused to their “I will…” commitment
“I will”… Binder Results

Total Falls per 1000 patient adjusted days

Falls Rate

<table>
<thead>
<tr>
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<th>4Q11</th>
<th>1Q12</th>
<th>2Q12</th>
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<tbody>
<tr>
<td>BHE</td>
<td>8.87</td>
<td>5.22</td>
<td>3.29</td>
<td>3.35</td>
<td>2.39</td>
<td>3.53</td>
<td>3.39</td>
<td>2.66</td>
</tr>
<tr>
<td>NDNQI</td>
<td>3.55</td>
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Falls Pamphlet

- Initially developed by Women’s Health unit
- A way to partner with patients/ families to reduce risk of falls
- The pamphlet was later adopted by the Rehab unit
Falls Pamphlet Results

Total Falls per 1000 patient adjusted days

- BHE: 4.00, 7.42, 7.10, 8.17, 1.84, 5.97, 2.08, 3.87
- NDNQI: 6.26, 6.51, 6.64, 6.57, 7.39, 7.11, 7.24, 6.98

Pamphlet roll out

Patient Education

Used pink paper to highlight new medications within discharge instructions

Percent of patients satisfied

- BHE: 99%, 99%, 99%, 99%, 99%, 100%, 99%, 99%
- Goal: 90%, 90%, 90%, 90%, 90%, 90%, 90%, 90%
Patient Education

Education cards to highlight pertinent info for recurring out-patients

Explanation by Staff

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>BHE</td>
<td>90%</td>
<td>82%</td>
<td>89%</td>
<td>90%</td>
<td>98%</td>
<td>92%</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>Press Ganey</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
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Percent of patients satisfied

Peri-Operative Units

Used group collaboration to improve integration

SCIP Card 2
Beta Blocker

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<th>4Q11</th>
<th>1Q12</th>
<th>2Q12</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCIP C2</td>
<td>94%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
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</tr>
<tr>
<td>Nat Avg</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
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General Initiatives
• Staff education
  – Poster, Tip of the month, Newsletters
• Adding a new step into an existing process
  – Checking bed alarms during hourly rounding
• Enhanced communication
  – Patient education
    • Scripting post procedure phone calls
  – Interdepartmental
    • Infection control sending real time results

The Harvest
Structure: NSI on every unit

Outcomes:
Improve patient outcomes

Process: Develop a Strategy

Implement initiatives
Present, discuss and develop action plans
Manage and analyze data
Showcase results
The project was congruent with the Professional Practice Model.

Outcomes

- Improved patient outcomes and general improvement in NSI
- Met the requirements for Magnet EP 32EO and OO 23 related to NSI for:
  - Falls, Restraints, HAPU, CAUTI, CLABSI
  - Most of the unit specific
Major Outcome

• Enhanced staff buy in, awareness and accountability in quality improvement
  – Increased independence in managing the template and staff participation in the process
  – Positive comments from staff and managers regarding the process
  – Unit projects have been presented at local symposiums

Implications for Practice

• Used data to improve outcomes and practice
• Created a culture of frontline accountability
• Cyclic process was adopted by other departments
Cultivators

• Refine the templates
• Share best practices across the units
  – Quality Council Recognition Award
• Continue to enhance staff participation and accountability in quality improvement

Future Steps

BAPTIST HEALTH
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References


Magnet Recognition Program (2008). Disseminate data to frontline staff members. *HCPro’s Advisor, 4* (8).

