Med-Surg CHURN

Marilyn Guidi
Lehigh Valley Health Network, Marilyn.Guidi@lvhn.org

Carolyn L. Davidson RN, PhD
Lehigh Valley Health Network, Carolyn_L.Davidson@lvhn.org

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Med-Surg Churn

Research Day 2012

Marilyn Guidi, Director, Staffing – Patient Care Services
Carolyn L. Davidson, Administrator, EBP & Clinical Excellence

WORKGROUPS

SPONSOR: Anne Panik

WORKGROUP MEMBERS

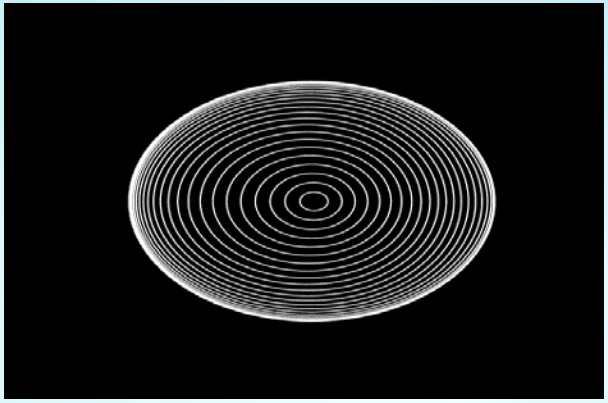
- Chair: Marilyn Guidi
- Kim Jordan
- Courtney Vose
- Maryann Rosenthal (5K, 6K)
- Lois Guerra (5C)
- Director (6T)
- Debra Sellers (4T)
- Tracie Merkle
- Carolyn Davidson
- Data: Stephanie Lenhart
- Secretary: Lori McMichael

TIME-MOTION STUDY

- Deb Halkins-Management Engineering
- Jane Dilliard-PCS
- Tracie Merkle-Nurse Interviewer
- Erin Brittingham-5B Staff Nurse
- Allison Greco- TTU Staff Nurse
- Michele Grietzer- FP Staff Nurse

SPPI EVENT: 4 Directors, 4 PCC, 8 Staff which included 3 from the original workgroup; 13 units and Float Pool representation

What is 'CHURN'



- 'Churn' is operationally described as a ***persistent phenomenon*** associated with patient admissions, discharges, transfers and the daily care workload that is accepted as the norm of healthcare. Within the norm and the 'churn' effect, systems inefficiencies are exposed and have the potential to negatively impact on patient and nurse satisfaction and outcomes.

Background

- Annual review of nurse to patient ratios
  - National Benchmarks
  - Conferences
  - Colleagues
- Nurse to patient ratios are adjusted as necessary to address a specific patient population (i.e. 5T—Acute Leukemics)
- Nurse to patient ratios are flexed to meet patient demands

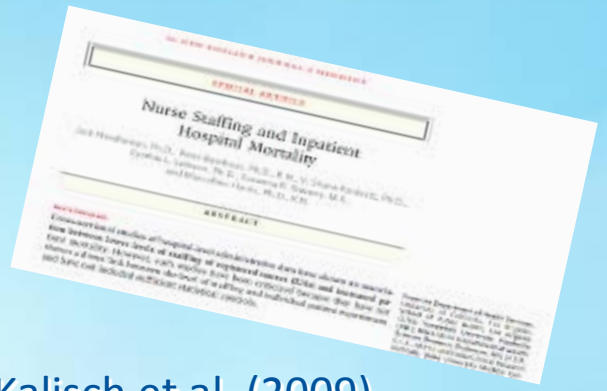
Background

- The ***'voices'*** of med-surg staff concerns were becoming consistent, and unit directors were not only recognizing and hearing, but ***'feeling'*** the escalating patient care concerns.

- Additionally, the ***float pool staff*** recognized and was verbalizing the obvious ***strain*** on the medical-surgical units that was not evident on the progressive or critical care units.

- These concerns were highlighted in rounds by administrators who addressed the initial wave, but ongoing issues continued to be brought forward about the burgeoning workload and feeling of ***"can't keep up."***

Background



- The issues were consistent with a literature article by Kalisch et al. (2009) which highlighted findings from the **MISSCARE** survey of 459 nurses.
  - The items most often missed were ***assessment (44%), interventions, basic care and planning (70%), ambulation (84%), medication effectiveness (83%), turning (82%), mouth care (82%), patient teaching (80%),*** **prn medication administration (80%), and bedside glucose monitoring (26%).**
  - The reasons for missed care were identified as: ***labor resources (87%), material resources (56%), and communication (38%).***

- And, a recent Needleman, Buerhaus et al. article in NEJM published March 17, 2011 stated in their conclusions, *"In this retrospective observational study, staffing of RNs below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs for nursing care".*

Current State

Examples of issues being voiced by staff:

- Patient turnover *(admission, discharge, transfer)* could result in a nurse caring for up to 12 patients per day
- System inefficiencies (paper v. electronic)
- Inefficiencies due to placement of Pyxis or tube stations
- Increasing patient acuity
- Expansive and high intensity nurse-managed protocols
- Patient throughput processes (‘*move on brown’)*
- Handoff Communication between departments and providers
- Interruptions

NOT JUST ABOUT RATIO

Analysis of the Problem

- Multimodal Approach
  - Qualitative data
  - Quantitative data

Outcomes

- HR and OD (Organizational Development) facilitated three RN Med-Surg focus groups:
  - Nurses with at least 2 years experience who work on the evening or night shift
  - Structured sessions to allow feedback from each nurse on five open ended questions developed prior to the meetings

Focus Groups

- 17 units participated (includes FP-CC and FP-M, 1-3 RN's per unit)
- 2 sessions at the Cedar Crest site and 1 session at the Muhlenberg site.
- 5 questions:
    1. What do you ***think*** about your ***workload***?
    2. What has ***changed*** in your ***workload***?
    3. What has ***impacted*** your ***workload***? --probing made it ***harder***?; made it ***easier***?
    4. What are ***barriers*** that you face during your shift?
    5. What two things would you ***change*** that would ***improve*** your ***workload***?

Outcomes

- **29 total RN's participated**
  - Shared *compelling perceptions* about their workdays relative to "not being able to provide optimal care in the current environment". This revolved around issues of communication, inefficiencies, and lack of supplemental labor resources.

LVH-CC
-Admissions
-Documentation
-I/S systems
-Meds
-Patient ED
-Physician and verbal orders
-Supplies-lack
-TPs-not enough
-Workload

LVH-M
-Admissions
-Communication
-Documentation
-Tubesystem availability
-Interruptions
-Physician coverage
-TP engagement
-Workload

RN Time-Motion Study

- Supported by Management Engineering
- Developed, tested and revised template for collecting data
- Interrater reliability established prior to observations
- Observations (n) occurred during the hours of 1500-2300 in 4 hour blocks on the following days:

  -Monday (n =1)

  -Tuesday (n =4)

  -Wednesday (n =5)

  -Thursday (n =4)

  -Friday (n =1)

Observations

- Completing Patient Safety Report at *end of shift* after report
- Expecting one admit, *four actually arrived* during 4-hour block
- RN interrupted so many times during discharge process *forgot to give patient script* – RN notified patient and patient returned to pick up
- Actual *reflection of six patient assignment:* 1 discharge, 1 admission, 1 transfer from ICU, 4 tele patients at end of shift
- RN makes *many trips to med room* for water or cups (meds in room)
- *Patients moving* to different rooms to accommodate assignments
- MD never put in *orders at night*, at home
- ED *patients show up*, no call to anyone

Outcomes

- **RN Time-Motion Study over 58 hours and 869 activities during the high 'churn' time indicated:**
  - nurses were **multi-tasking** at a minimum, **33%** of the time
  - activities consuming **61% of their time are direct patient care**, documentation, and medication delivery
  - **most activities take less than 2 minutes**, further validating the pace of the workday

TYPE	NUMBER	%
Main Activity + 1 Task	285	32.8
Main Activity + 2 Tasks	118	13.58
Main Activity + 3 Tasks	52	5.98
Main Activity + 4 Tasks	22	2.53

Primary ACTIVITY	NUMBER	%
Direct Patient Care	212	24.4
Documentation	168	19.3
Medications/IV	152	17.5
Coordination of Care	121	13.9

Outcomes-Interruptions

- RN Time-Motion Study over ***58 hours*** during the high 'churn' time indicated:

Interrupter	Number
1. Patient call lights	10
2. Other staff	7
3. Other	5
4. Phone Interruptions-provider	5
5. Phone interruptions-other	4
6. Family	4
7. MD/provider	3
8. Ancillary Service	3
9. Pharmacy	2

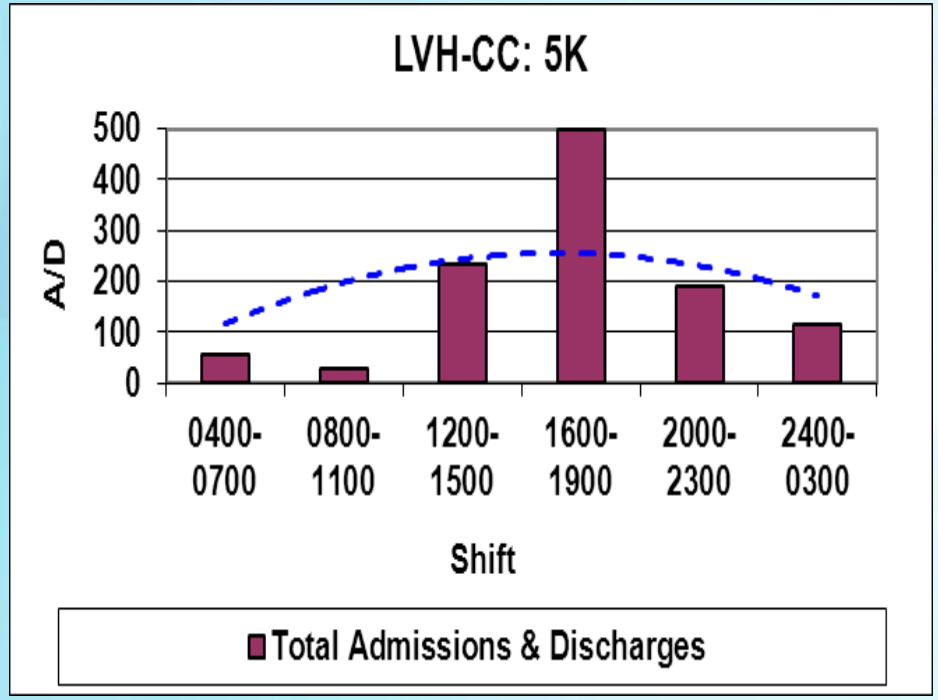
And…

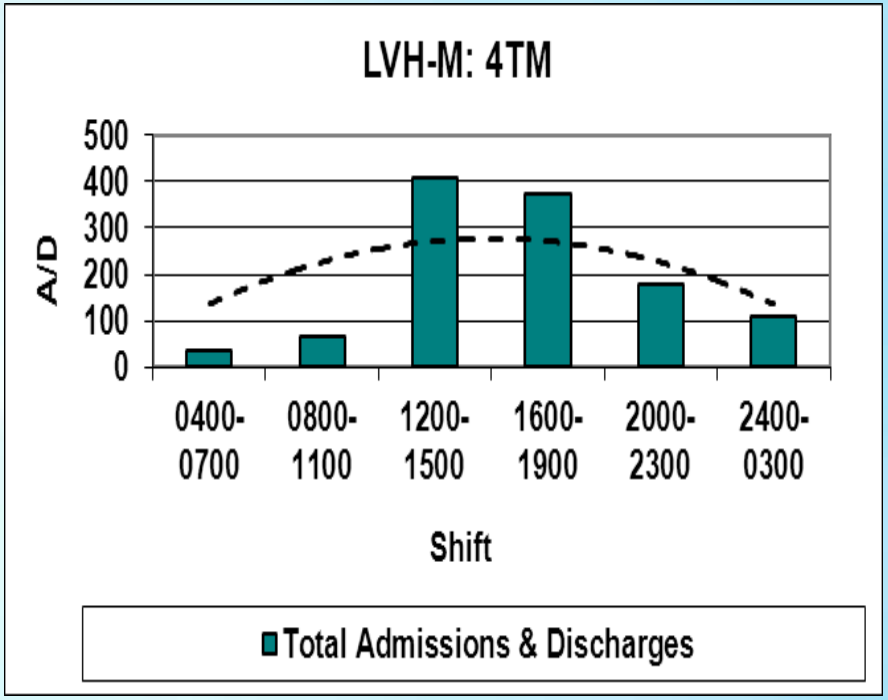
- One observer stated, "*never once* during the medication administration process in my fours of observation did a nurse not get interrupted."

Why so Chaotic?

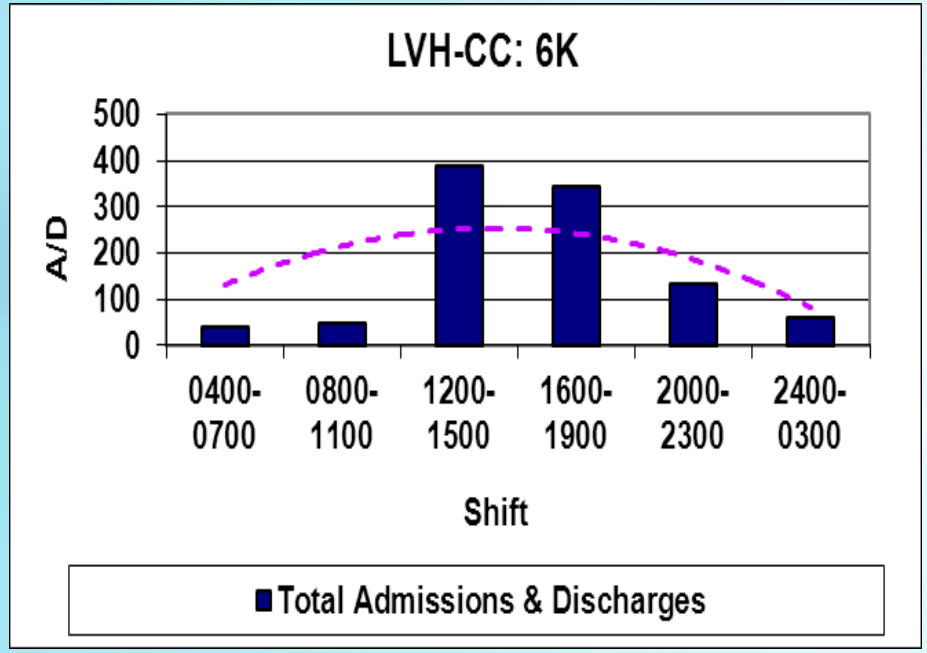
- Nurses struggling with workload
- Snapshot of the flow on a Med-Surg Unit

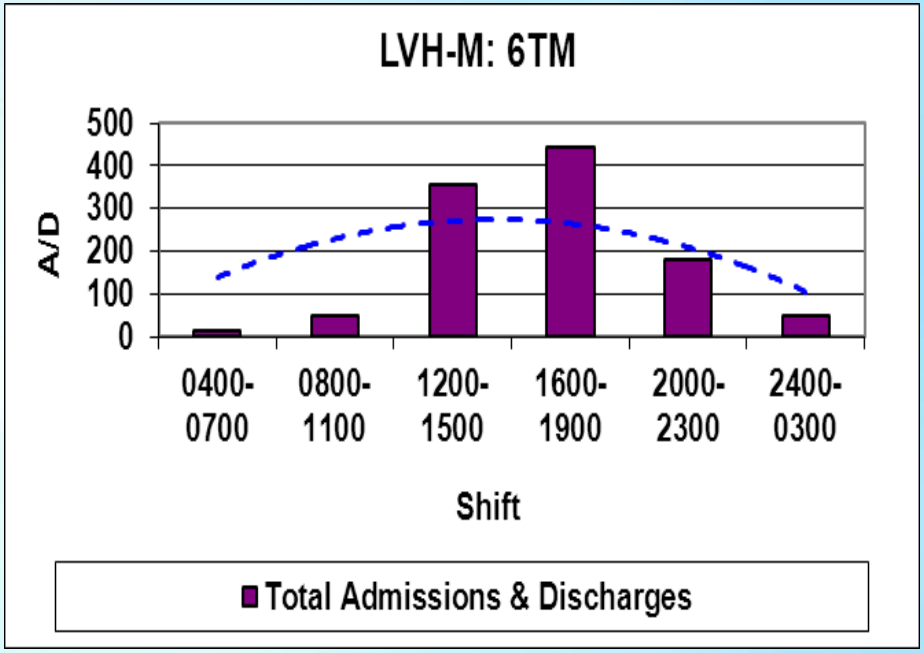
Admissions/Discharges





Admissions/Discharges

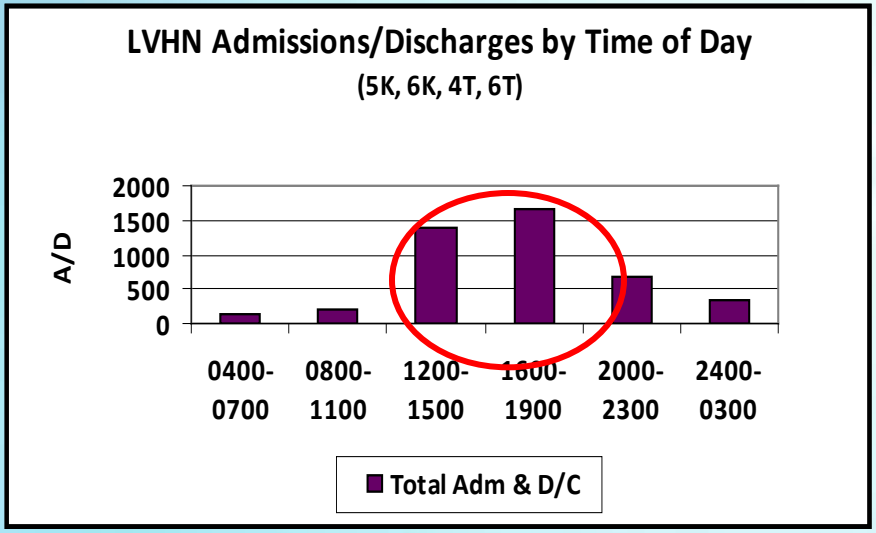


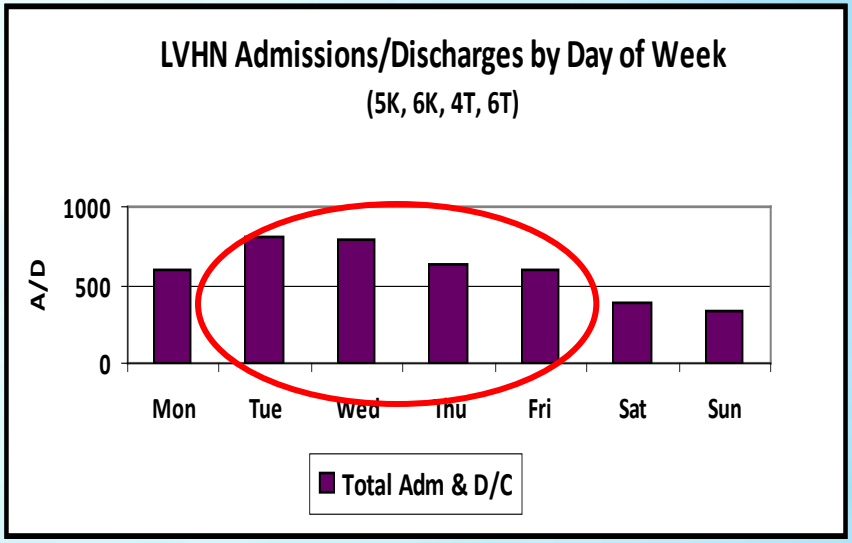


Admissions/Discharges

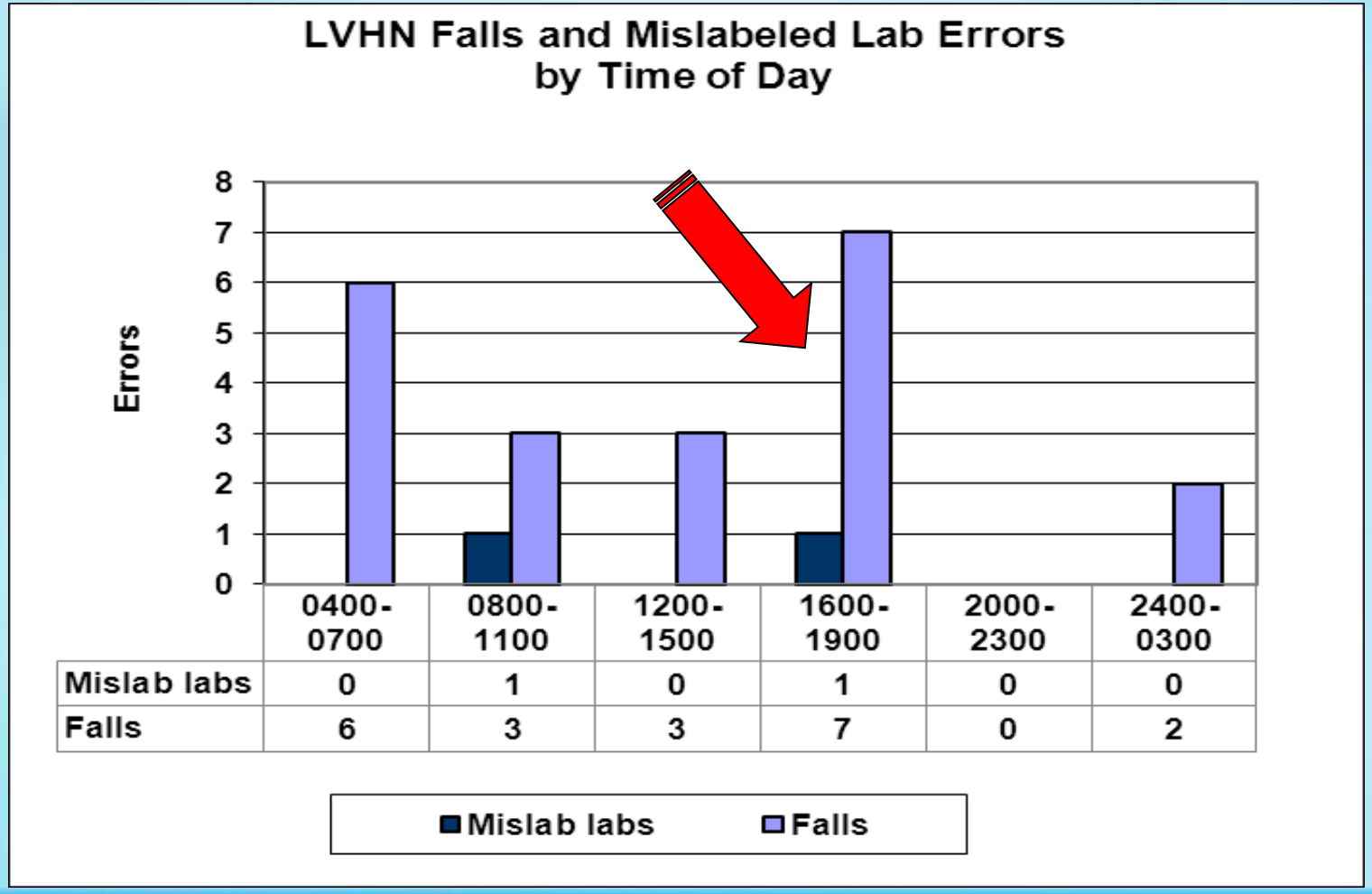
- A sample of unit data indicated the 'churn' begins at 1200 and does not decrease until 2400, with a peak on the days of Tuesday and Wednesday.

  ***This does not account for transfers from other units.



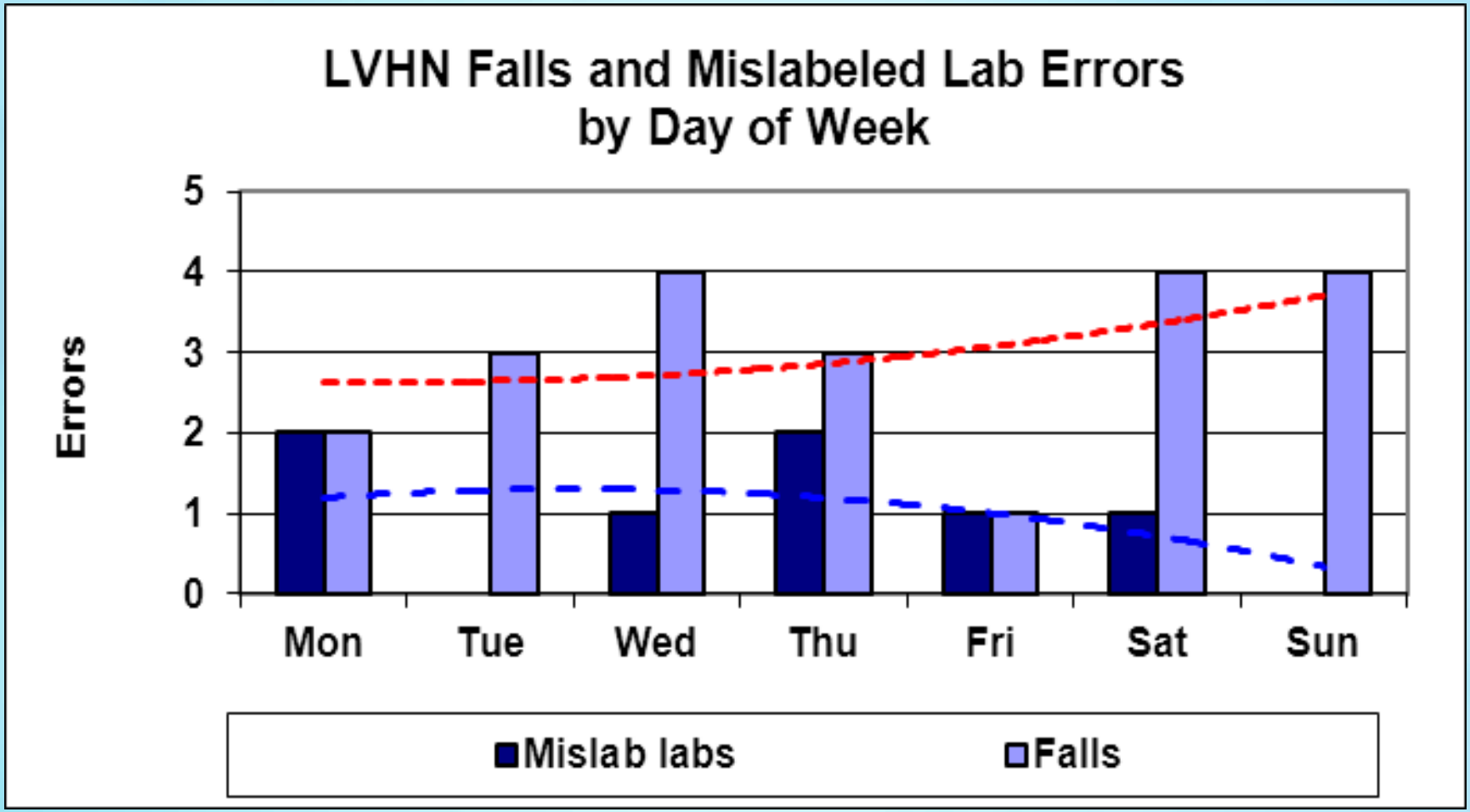


Quality Issues/Time of Day



	0400-0700	0800-1100	1200-1500	1600-1900	2000-2300	2400-0300
Mislab labs	0	1	0	1	0	0
Falls	6	3	3	7	0	2

Quality Issues/Day of Week



Outcomes

- Recommendations to Senior Leadership
  - Increase of FTE Base **(1.6 FTE/unit) for 11 medical-surgical units** between the hours of 1100 and 2300 was approved for FY12

    $1.5 Million Labor Budget
- Identified process issues along the journey to work towards improving
- Standard process for labor budget on Med-Surg Units with ≥ 30 beds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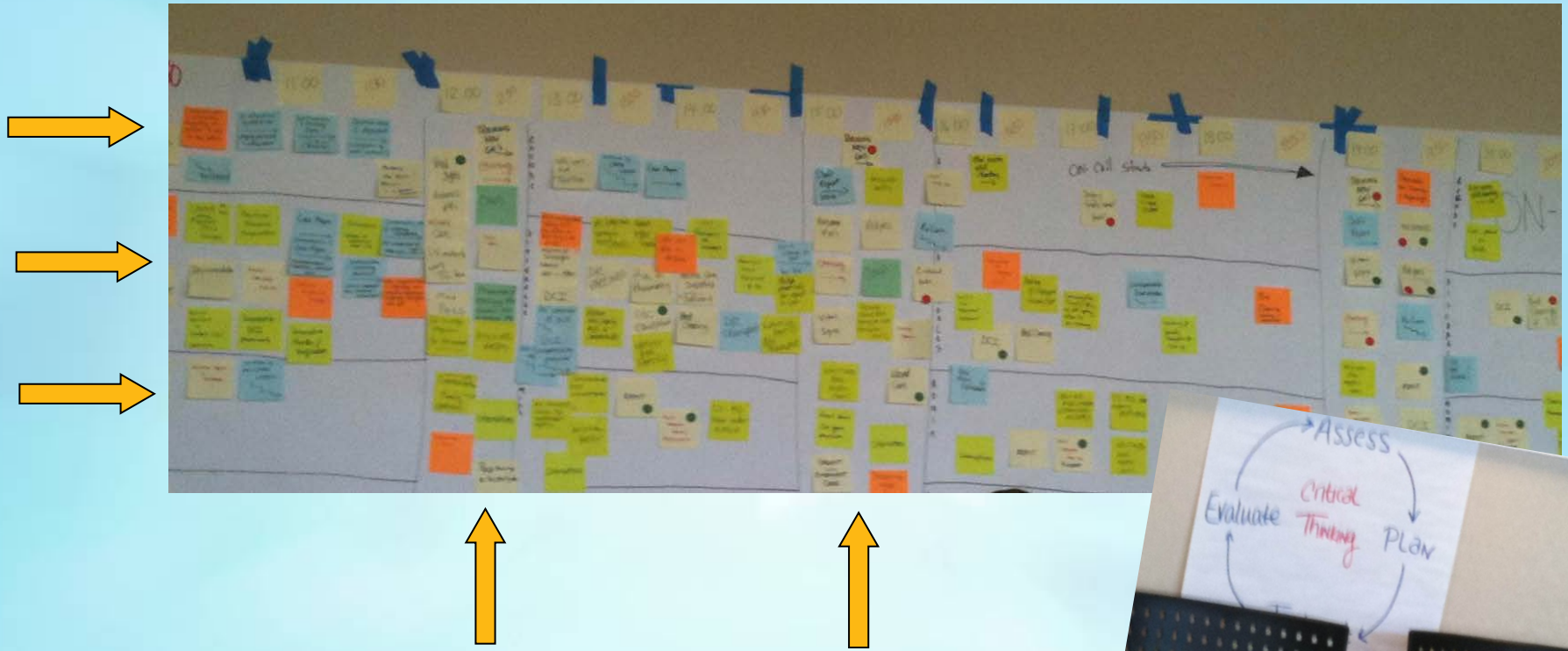
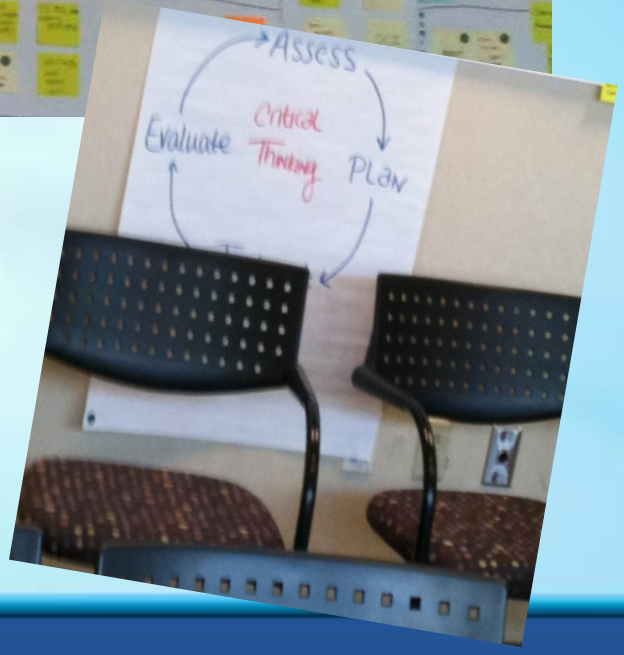
Next Pieces of the Puzzle

2 ½ day SPPI Event

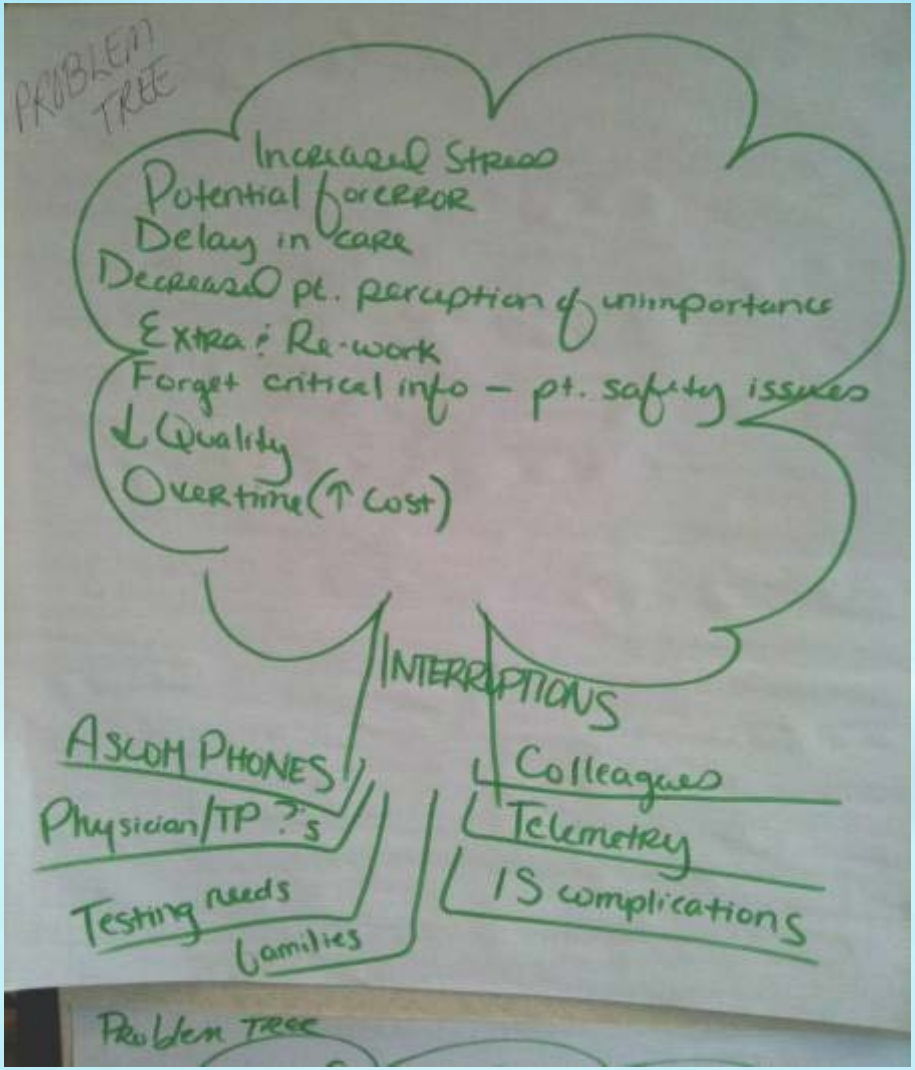
- PURPOSE:
  - Develop standard roles/responsibilities to address the problems
- 20 participants (directors, PCC, Staff)
  - Representative(s) from each unit
- 3 “P” Model
  - Production, Preparation, Process
    - 7 Ways or Models are developed
    - “Moonshined” into 1 or 2 models

A Picture's Value





Problems and Possibilities


PROBLEM TREE
Increased Stress
Potential for ERROR
Delay in care
Decreased pt. perception of unimportance
Extra Re-work
Forget critical info – pt. safety issues
↓ Quality
Overtime (↑ cost)
INTERRUPTIONS
ASCOM PHONES
Physician/TP ?'s
Testing needs
Families
Colleagues
Telemetry
IS complications
Problem Tree

Model Selection

Standard Work

6S

Tight Connection

1X1 flow

Key Tasks and Characteristics
Meal Break Relief (scheduled):
Coordinated Unit Communication:
Checklist of duties
Consider coverage for shift changes
Acuity - use 'bed ahead'
No Patient Assignment
Structured Times for 11 - 11 Support/Relief
1x1 Flow for Charting
Standard Work

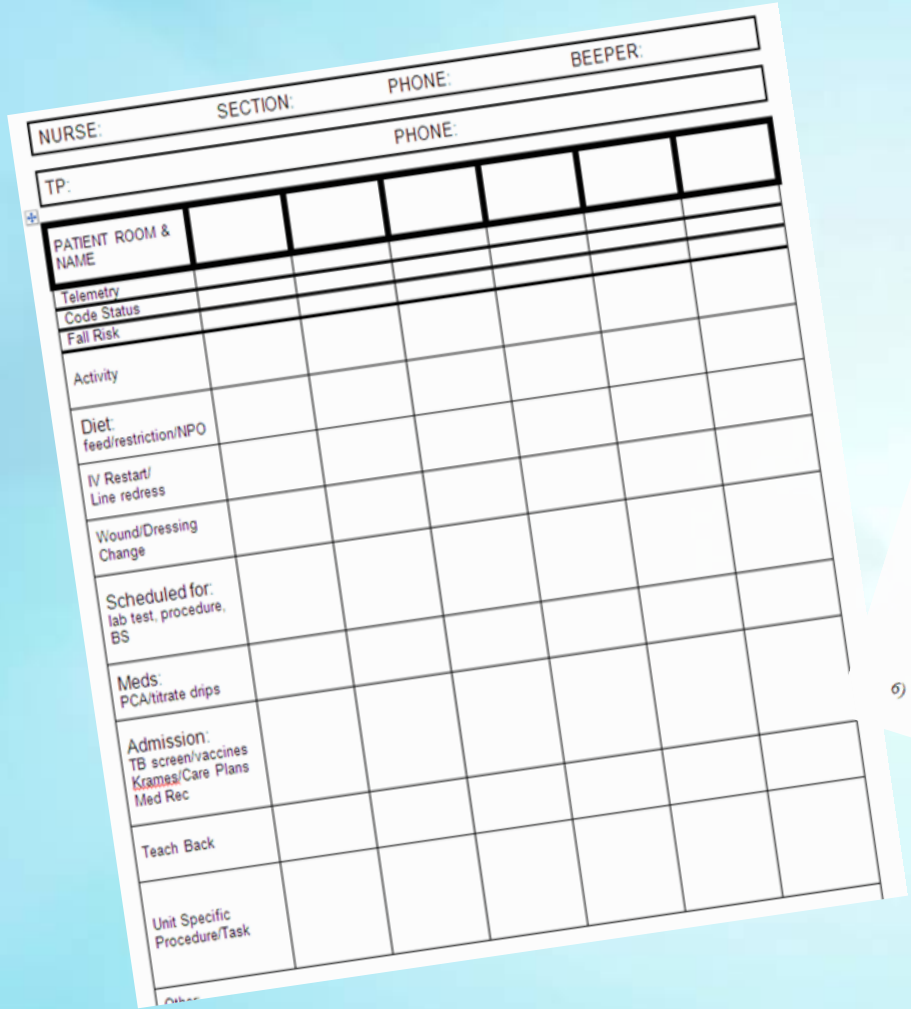
The "CHURN" Model

- STANDARDIZATION
  - Develop checklists and standard work for the unit and "CHURN" RN
- Directors, PCC's and staff nurses from the representative units were assigned to one of six teams for the action items and testing phase
- Evaluation of the model effectiveness

Standardization

Med/Surg Churn Model Development				
Action Teams				
Topic	**Lead**	**Support**	**Process Owner Support**	**Notes**
Meal Break Structure and Structured Relief/Support provided by 11-11 Nurse	Angie	Todd, Kelly Erb, 4T/7T	Marilyn Guidi	
Checklist Development	Deb	Lori, Tammy Gallagher (5C), 4T/7T	Carolyn Davidson	
Standard Work	Amber	Lori, Christine, Kelly,Chrissy Schirer	Marilyn Guidi	
Education and Communication Plan	Lois	Maryann, 6T, Marketing	Marilyn Guidi	Communication Plan includes: Tasks for 11-11 Nurse, Responsibility(ies) of Primary Nurse , Sample of activity in the shift
PDCA (Staging, phasing and conducting testing)	Allie	Tracey, Nicky Melneck	Carolyn Davidson	
Measurement Team	Jody	Sue G, Pam Carrion	Carolyn Davidson	

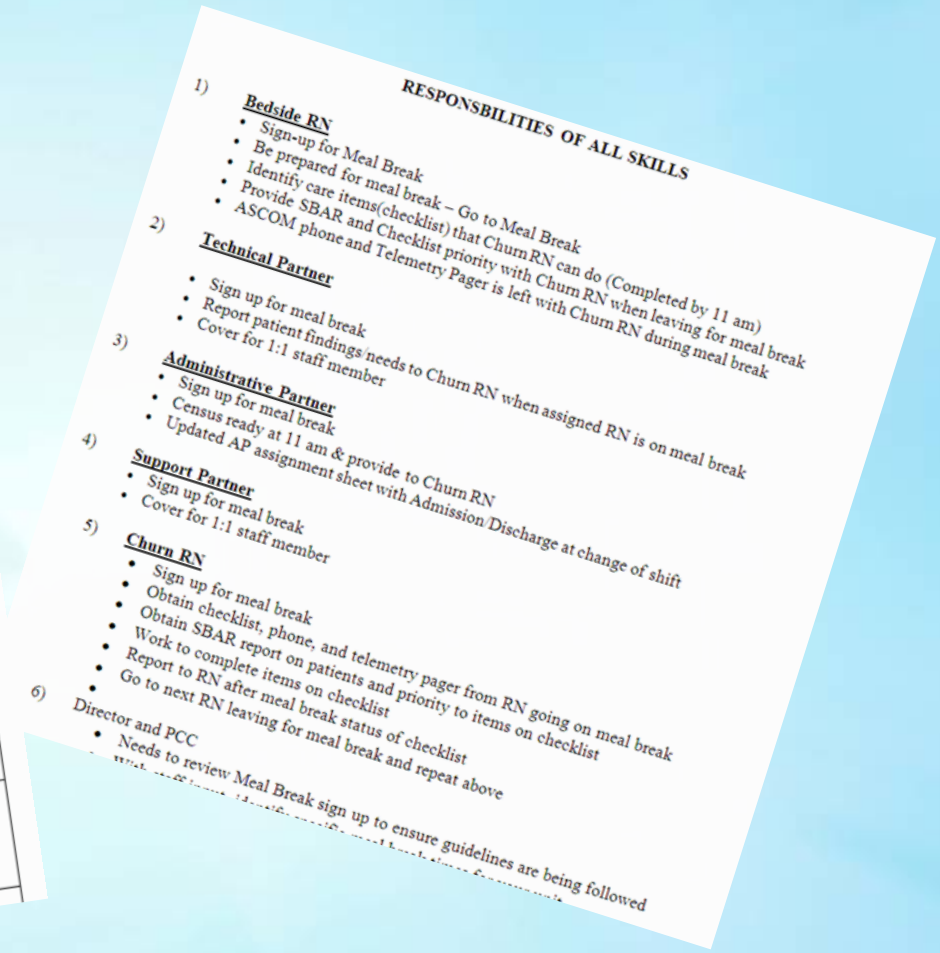
Outcomes



NURSE: SECTION: PHONE: BEEPER:

TP: PHONE:

PATIENT ROOM & NAME						
Telemetry						
Code Status						
Fall Risk						
Activity						
Diet: feed/restriction/NPO						
IV Restart/ Line redress						
Wound/Dressing Change						
Scheduled for: lab test, procedure, BS						
Meds: PCA/titrate drips						
Admission: TB screen/vaccines Krames/Care Plans Med Rec						
Teach Back						
Unit Specific Procedure/Task						
Other						



RESPONSBILITIES OF ALL SKILLS

1) **Bedside RN**
- Sign-up for Meal Break
- Be prepared for meal break – Go to Meal Break
- Identify care items(checklist) that Churn RN can do (Completed by 11 am)
- Provide SBAR and Checklist priority with Churn RN when leaving for meal break
- ASCOM phone and Telemetry Pager is left with Churn RN during meal break

2) **Technical Partner**
- Sign up for meal break
- Report patient findings/needs to Churn RN when assigned RN is on meal break
- Cover for 1:1 staff member

3) **Administrative Partner**
- Sign up for meal break
- Census ready at 11 am & provide to Churn RN
- Updated AP assignment sheet with Admission/Discharge at change of shift

4) **Support Partner**
- Sign up for meal break
- Cover for 1:1 staff member

5) **Churn RN**
- Sign up for meal break
- Obtain checklist, phone, and telemetry pager from RN going on meal break
- Obtain SBAR report on patients and priority to items on checklist
- Work to complete items on checklist
- Report to RN after meal break status of checklist
- Go to next RN leaving for meal break and repeat above

6) Director and PCC
- Needs to review Meal Break sign up to ensure guidelines are being followed

Interim Findings

- 1 month after implementation:
  - Employee survey in November 2011 elicited a least one (1) qualitative comment from every unit about the value of the role.
- Based on one unit's experiment with the Churn nurse being accountable for reviewing completeness of Med Rec-the compliance improved from 83% to 94%.

1-YEAR LATER

- Staff RN perceptions improved from baseline to 4-months
  - ON A SCALE OF 1 to 10, with 1 being out of control and 10 being highly controlled, RATE your typical day on this unit?
    - **Pre: 58.5% (n=138) rated day 6-10.**
    - **Post: 75% (n=274) rated day 6-10.**
  - In general, how would describe the quality of nursing care you deliver to your patients? Rated as excellent
    - **Pre: 26% (n=73)**
    - **Post: 36% (n=120)**

1-YEAR LATER

- Orientation plan for M-S Churn Nurse Role
- Revision of Checklist
- 1-year Staff Satisfaction/Perception Survey (COMING SOON)

Next Steps

- FY 2013 – each unit has identified a quality outcome for the M-S Churn nurse to impact
- MISSCARE Nursing Research Study (January)
  - Kathy Baker
  - Dr. T. Bernecker (Academic Partner)
  - Dr. M. Pasquale (Academic Partner)

Questions?

Contact Information:

marilyn.guidi@lvhn.org
carolyn_l.davidson@lvhn.org

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