Bed Placement
Barrier Reduction

Danica Chadwick
Kevin Clay
Dawn Gilbert
Janine Holbrook
Roni Lyons
Autumn Moser
**Problem Statement:** Current bed placement processes are multi-step, complex, lack clear algorithms/standardization and result in flow failures. We have open beds yet have patients waiting for placement.

**Aim Statement:** Increase the use of universal placement options via a reduction in artificial barriers resulting in decreased patient wait time (ED, OR, Community). Develop more open access to beds. No increase in patient moves (ideally decrease moves).

**Outcome Measurement:** Patient wait times (Ready to move to assign); Patient moves (manual metric)

**Balancing Measures:** Overall cost, patient safety

**Project Scope:** Decision to admit to discharge

**Forecasted Financial Benefit:**

**Strategic Alignment:** Transforming our Future

**Project Sponsor:** Liga Mezaraups

**Process Owners:** Janine Holbrook

**Team Members**
- Roni Lyons
- Danica Chadwick
- Dawn Gilbert
- Autumn Moser
- Kevin Clay

**Other Members:**
- Admin sup team, Charge nurses, Renee Porter
We promise to eliminate artificial placement barriers while reducing wait times and patient bed moves.

**Customer Promise Tool**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Departments</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No waiting</td>
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</tr>
<tr>
<td>2. Know the plan</td>
<td>2. Right patient placement</td>
<td>2. One call</td>
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<tr>
<td>3. No unnecessary moves</td>
<td>3. No open beds if patients waiting</td>
<td>3. Care for patient</td>
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*An ounce of performance is worth pounds of promise.*  

Mae
INITIAL PROBLEM:
Current patient placement processes are complex, prohibitive and result in flow failures

CLARIFY PROBLEM:
There is a need to reduce artificial barriers that cause wait time, patient moves and frustration

LOCATE PROBLEM:
Developed a list of 19 barriers to address

IDENTIFY TEST SITE:
PACU to 10th floor

5 WHYS:
- There is a delay in moving patients from PACU to 10th floor
  - Why? 1. There is not a clean, ready bed for the patient on request
  - Why? 2. High patient census with limited to no bed availability
  - Why? 3. Need to wait for clean bed and RTM to be done before assigning bed
  - Why? 4. Following agreed upon process
  - Why? 5. A way to assure that patient would arrive to clean and ready room

ROOT CAUSE: Sequential and/or contingent processes

COUNTER MEASURE: Parallel/Concurrent processes
Planned changes tested:
Developed a process to work concurrently instead of sequentially to reduce throughput time from PACU to 10’s. Transfer Center initiated targeting a bed assignment while the bed was in the cleaning process for RN to RN report to be done in parallel. Transport moved the patient at the time the bed went to clean so bed cleaning could occur in parallel with RN to RN report.

Predictions:
Parallel processes will decrease the amount of time a patient spends waiting in the PACU to be moved to the 10th floor.

How many caregivers were involved in your PDSA Cycles?
One admission area, one inpatient unit (10N), one patient population, one transport team and Transfer Center Staff.
Post PDSA data:

PACU to 10th floor Ready to Move to Assign time

Decreased 27 minutes
Pebble In The Pond

Big Lessons Learned:
- What were your high level lessons learned?

The concept of small tests of change

One Patient, One Unit
PDSA it!

Be creative to find your “one”

Organization Readiness:
- How can the organization and/or community structure be used to facilitate spread?
- What process enhancements will assist in achieving the spread aim?

Team based PDSA to improve and change

Leaders mentoring teams in the processes

Leaders do not manage people, leaders manage processes and develop/coach people to improve processes for our patients.

People Readiness:
- How did this team help other leaders inspire organization-wide adoption?
- Who will you coach within 3 months & ongoing to be the “Pebble in the Pond” to continue to grow continuous improvement capability at NWSA?

Sharing and spreading the new process
Celebrating the wins
New tools being used at unit and team level

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- One Patient, One Unit
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- Be creative to find your “one”

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author unknown
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<tr>
<th>Toni Booker</th>
<th>Rebecca Carbajal</th>
<th>Kyle Cramer</th>
<th>Najwa Elmorr</th>
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<tr>
<td>Cheryl Grohn</td>
<td>Kim Leppert</td>
<td>Devorah Overbay</td>
<td>Renee Porter</td>
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<td>Melissa Tsay</td>
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**Problem Statement:**
50% of Daily surgical inpatients have consents not complete properly for the scheduled surgery/procedure creating delays on scheduled wheels in time to OR/Procedural areas.

**Aim Statement:** Inpatient surg/proc patients will have 75% of the consents correct and complete for their Surgery/procedure upon arrival to pre-procedural area within 6months of launch of this initiative.

**Outcome Measurement:**
Number of Inpatients arriving in Pre-Op with consents completed.

**Project Scope:**
Surgical/Procedural 10N inpatients scheduled for a surgery or procedure, excluding:
- Urgent/emergent trauma patients

**Forecasted Financial Benefit:**
Soft dollars associated with increased efficiencies.

**Strategic Alignment:**
Strengthen the core.

**Project Sponsor:**
Liga Mezaraups

**Process Owners:**
Toni Booker

**Team Members:**
Rebecca Carbajal, Cheryl Groen, Najwa Elmor, Renee Porter, Peggy Canell, Kim Leppert, Kyle Cramer, Devorah Overbay

**Triad Members:**
James Cook

**Patients = INPATIENTS**

**Pre-Op = ADMISSIONS**
First CVI Meeting
- Broke into assigned groups
- CVI Project explained
- Project handed to group

Combine with Documentation CVI Group
- Pre-Op Documentation Group & Pre-Op Inpatient Readiness Group combined.
- Very similar needs.

Combined
- Charter & Resources
- Meetings.

2 become 1, then blend, build & PDSA
Goals:
1. Safe Care
2. Efficient Care
3. Compassionate Care

Goals:
1. Clear & Concise Process
2. Standard Work

Goals:
1. Standard Work
2. Efficient & Timely Care
3. Decrease Surgical Delays

Customer Promise Tool

We promise………Safe and seamless workflow for surgical in-patients.

An ounce of performance is worth pounds of promise. Mae
Inpatient having surgery: NOT READY RCA.

**TRANSPORTATION**
- Transport request not entered in teletracking when transporters called
- Transport is not calling Nsg unit when picking up PT
- Delays on Nsg Unit
  - No C of when PT will arrive
  - PT or Unit “Not Ready”
- Not prepped
  - Lack of Ed of what prep should be
  - No order written for protocol
- Change protocol
  - PT or Unit “Not Ready”

**COMMUNICATION**
- PT not aware of surgery plan
- Poor hand off
  - unit staff
  - doc 2 doc
- Cleared by other MD groups but issues not resolved
  - Pacemakers
  - GST
- HUC upon transfer
- No “grace” period
  - When PT called for
  - When OR time changes
- Unit staff not aware
  - No order
  - No time
  - No verbal C of surgery plan

**DOCUMENTATION**
- No protocol on who charts what
- No flow” btw flow sheet & navigators
- Variety of areas to chart
  - No standardized format
- Inpatient staff not completing Pre-Op checklist
  - Told not to
  - Understand they don’t have to
  - “not my job”
  - Workflow changed w/Epic implementation?
- CHG documentation
  - Quick chart does not flow

**CONSENT**
- Not done
  - No order
- Not seen by MD
  - Staff Ed
  - Order incorrect
- PT can’t legally consent
  - Family not available

**C=Communication**
PT= Patient
Ed=Education

PT does not arrive to Pre-Op READY for Surgery

**PREP**
- Lack of Ed
- Lack of Fam info
- Incorrect Fam contact info
- PT does not know they are having surgery
- Pre-Op stall → not calling for PTs in timely manner

**PEOPLE: Staff, PT, Family**
- Staffing issues
  - Too many phone calls
  - pt traffic arriving & leaving
- What does READY mean?
  - No definition
Homework Session - Looked at project Time Line

• Meetings every 1-2 weeks to work on project. Hard to get together and plan next steps. Lots of talk-minimal results-micro positive forward movement.

Freak-Out Moment

• Motivated the team to move forward and realized our focus was too wide for timeline.

Narrowed Focus

• Need Data!
Baseline Data

“Data provokes questions; it does not deliver answers.”

Ari Robicsek

Pre Op Ready Checklist

☐ Consent completed correctly

☐ CHG bath completed and documented (Inpatient charting may be in Quick Chart flow sheet)

☐ Pre-Op ordered released

☐ Orders Completed  ☐ Order(s) not completed, list what order(s) in comments

Comments: ________________________________

☐ IV 20G or bigger  ☐ Working IV

☐ Recent set of Vital Signs (T, P, BP, RR, SpO2, O2 device) within 1 hour

☐ Blood sugar checked if ordered

☐ Charted recent assessment

☐ Pacemaker orders present if patient has pacemakers

☐ Voided and documented prior to arrival to Pre-Op

☐ Arrives to Pre-Op in gown and hospital socks only

☐ Dentures, glasses, teeth, and jewelry all removed and documented

☐ If sent with patient arrived with cup/case with patient label
Plan-Do-Study-Act #3

Planned changes tested:
Consent Tip-Sheet PACKET
SPREAD & TEST: 3A, 3C, 4A, 4C, 5A, 6A, 7A, 6N, 6S, 7S, 7N, 8N, 8S, 10N, 10S

Predictions:
Consents will be filled out completely and properly if the tip sheet is readily available for reference.

Results:
Crickets...

How many caregivers were involved in your PDSA Cycles?
15 contacts with zero spread.
CC Run Chart

**Graph Details:**
- **Title:** Percent
- **Y-Axis:** Percent of Completed Consents
- **X-Axis:** Dates from 4/9/2018 to 5/4/2018
- **Legend:**
  - SURVEY
  - PDSA #1
  - PDSA #2
  - PDSA #3
  - PDSA #4

**Key Events:**
- **4/9/2018:** 50%
- **4/17/2018:** 100%
- **4/18/2018:** 100%
- **4/27/2018:** 0%
- **5/4/2018:** 100%

**Notes:**
- The graph shows the progress of completed consents over time, with various PDSA initiatives.
Pebble In The Pond…

Big Lessons Learned:
• Spreading too big too soon does not work.
• The point person needs to be the person that will manage the process on the unit not just pass the message along.

Organization Readiness:
• There is no well defined process for unit spread of practice improvement. Many things have been tried with varying results.

People Readiness:
• QUESTION: What’s in it for me? → needs to be answered for unit nurses before effective project spread.
• Focus on 10N to develop an effective process then target 10S next [spread slow to be effective; continuous process improvement coaching as we spread].

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