Triage: A Process, Not a Place

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Eric Rebraca, MHA, BSN, RN – Adm. Nurse Manager, Emergency Services, OhioHealth
Tina Solazzo, BSN, RN – Clinical Nurse Manager, Emergency Services, OhioHealth
Everett Haley, RN – Clinical Staff Nurse, Emergency Services, OhioHealth
Objectives

• Describe how to effectively engage front line associates in process change.

• How we changed our problem solving process.
  – Review keys to rapid cycle change in the clinical setting.

• Review managing communication across disciplines.

• Review the interpersonal elements of rapid cycle change.
OhioHealth Riverside Methodist Hospital

- OhioHealth’s largest member hospital
- 885 beds
- One of the busiest level-II trauma centers in the country
- Accredited Comprehensive Stroke Center
- Magnet designation
Riverside Methodist Hospital Emergency Department

- 96 beds
- Over 225 associates
- More than 87,000 visits each year
- Average daily volume of 250 visits
Emergency Department Challenges

- Implementation of new electronic medical record.
- Opening of the neuroscience tower leading to changes in acuity.
- Increase in behavioral health volume in the ED.
- Associate turnover, development and growth.
Setting the Foundation for Rapid Cycle Process Change
Address ‘Basic Level’ Needs

• Associate safety / Patient Safety
• Consistent staffing
  – Eliminated several shifts, not associates
• Ensure accountability
  – Restructured leadership model
    • Project management/Process Improvement training
  – Developed communication feedback loop
• Consistency in operations
  – Develop charge nurses
  – Charge nurse created standard work
• Provide a venue
  – Implement shared governance
Foundation Developed

Left Without Being Seen %

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
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<td>FY15</td>
<td>2.4%</td>
<td>2.2%</td>
<td>1.8%</td>
<td>2.0%</td>
<td>6.1%</td>
<td>7.1%</td>
<td>6.6%</td>
<td>4.7%</td>
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Target: 2.0%

Door to Provider (Min)

<table>
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<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Apr</th>
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<td>44</td>
<td>41</td>
<td>39</td>
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<td>28</td>
</tr>
</tbody>
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Target: 30

Legend:  
- Average  
- Median  
- Target
PDSA Cycle for Triage Process Improvement
The PDSA Cycle

**ACT**
Plan the next cycle
Decide whether the change can be implemented

**PLAN**
Define the objective, questions and predictions. Plan to answer the questions (who? what? where? when?)
Plan data collection to answer the questions

**STUDY**
Complete the analysis of the data
Compare data to predictions
Summarise what was learned

**DO**
Carry out the plan
Collect the data
Begin analysis of the data
The Plan

- Defined our objective to implement best practice and be a leader in ED throughput performance.
- Collected data about current process performance.
- Identified the value moments to improve upon.
- Channeled the voice of the associates through shared governance.
- Research emergency room throughput evidenced based practice.
Set Goals

• Left without being seen less than 1% by January 5.
• Door to provider time of less than 30 minutes by January 5.
Implement an Experiment

• Met a week before a go-live date.
  – Review current state in detail
  • Start of the interpersonal challenges.
  – Mapped ideal state
What made this experiment different?

• Expressed the problem **with data**.
  – Associates felt the inefficiency of the process.
  – The data validated their feelings, guided action and allowed for better questions.

• Current state process mapping.
  – Allowed associate input but **channeled it towards the future state with questions.**
    • Ask the question, listen, trust the answer.
    • **Redirect and refocus quickly.**

• Mapped out a future state process.
  – Generated creative ideas through “**what if...**” and “how could we..”
  – Adjusted the map **real-time or immediately following a lesson learned.**

• Reviewed data **frequently** to assess progress.

• Reduced variables in practice by utilizing a core group of staff members who were **change ready.**
  – Focused on easy replication to expand outside these associates.
Working with Barriers

• Staffing
• Patient arrival by time of day
• Include ancillary departments when appropriate
Study the lessons learned daily.

- Metrics were reviewed daily to learn from failures.
- Celebrated success.
- Communication between associates, department leadership, and providers occurred daily to identify areas of opportunity.
- Other key department metrics were monitored.
Act on lessons learned

• Changes were made to the process daily to address areas of opportunity.
• Rooms were reallocated to the triage area.
• Communication methods between the triage area and other areas in the department were altered.
• Meetings moved from the conference room.
Results
What improved?

- Door to provider **sustained** at less than 30 minutes
- Left without being seen **sustained** at less than 1%
The "voice of the customer" is a process used to capture the requirements/feedback from the customer (internal or external) to provide the customers with the best in class service/product quality.

- Who is the Customer?
- Is it always the patient? Can there be more than one?
- How do we get the Voice of the Customer?
- Why is the VOC important?
Customer Service

Overall Rating of ED Care
Mean Score by Visit Date (as of 9/30, Sept n=67 vs. avg. 240)
Lessons Learned
Keys to rapid cycle change in the clinical setting

• Foundation.
• Achieve quick wins to advance culture of change.
• Buy-in on a common problem.
• Don’t wait for perfect conditions to implement a change.
Effectively Engaging Front Line Associates

- Share the why and connect to their experiences.
- Ask questions and be okay with the response.
- Empower associates to make changes.
- Share the results as quickly as possible.
Managing Communication Across Disciplines

• Understand variations in communication needs.
• Daily communication through huddle process.
• Management team support.
• Define and document the standard work.
  – Make it visual!
Managing the Interpersonal Elements of Rapid Cycle Change

• Understand and **acknowledge** that people are at different points in the change process.

• Manage to the 80% and work towards 100%.
Conclusion
Make the Change You Want!

• Be bold in the change you want to achieve. Failure is okay!
• As a leader, channel the fear of failure towards improvement.
• Front line engagement = sustainment.
• **Rapid** cycle in a large, complicated clinical setting is possible. Never settle for current results and keep the forum open.
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MARION GENERAL HOSPITAL + REHABILITATION HOSPITAL + O’BLENESS HOSPITAL + MEDCENTRAL MANSFIELD HOSPITAL
MEDCENTRAL SHELBY HOSPITAL + WESTERVILLE MEDICAL CAMPUS + HEALTH AND SURGERY CENTERS
PRIMARY AND SPECIALTY CARE + URGENT CARE + WELLNESS + HOSPICE
HOME CARE + 28,000 PHYSICIANS, ASSOCIATES & VOLUNTEERS