

CUTTING WASTE SO NURSES CAN BETTER CARE FOR PATIENTS

PRAIRIE LAKES HEALTHCARE SYSTEM

- ◆ Watertown, SD
- ◆ 81 beds
- ◆ www.prairielakes.com

Prairie Lakes Healthcare System is a rural hospital serving 85,000 people in a seven-county service area in northeastern South Dakota.

STEEEP

Safe

Workflow and technology enhancements around medication administration helps provide safer care with fewer interruptions during the administration process.

Efficient

Significantly improved the HPPD productivity performance.

Patient-centered

Dramatic increase in the amount of time nurses spent in direct patient care.

THE PROBLEM

Administrative burdens and inefficient processes left nurses spending just one-third of their time caring for patients on the 52-bed medical/surgical unit. Most of their time was doing paperwork, hunting down supplies, documents and people and other non-direct care activities. Nurses likened working on the unit to hard labor. Nurse turnover was 65 percent.

THE SOLUTION

Patient-centered care, as the IOM points out, is a foundational domain of high quality health care. To provide such care, nurses need to be able to spend more time providing direct patient care. Nurses undertook wide-ranging steps—including technological, workflow and communication changes—in order to get nurses back to what they do best, caring for patients.

RESULTS

- » Nearly doubled the amount of time medical/surgical nurses spent directly caring for patients, from one-third of a typical shift in 2001 to approximately 60 percent today.
- » Reduced nurse turnover rate from 65 percent in 2000 to less than 10 in 2008.
- » Admission time decreased from an average of 90 minutes to 15 minutes.
- » Readmission rates continue to drop; 30-day medical/surgical readmission rates dropped from 7 percent in 2006 to 5 percent in 2008. (National rates are approximately 18 percent.)

BACKGROUND

Taking good care of our neighbors was an impetus for removing waste and barriers in the hospital's patient care processes, Prairie Lakes' CEO Paul Hanson says. The goal—getting nurses back to providing direct patient care. Doing so would bring returns for the hospital, leaders figured, including reducing nurse turnover rates. But how an organization implements this can spell the difference between success and failure.

"It really comes down to understanding and trusting the nurses," Hanson says. "We in the C-suite have to trust our line staff, and we did."

With that trust, the nurses shook up the medical/surgical unit. "The work intensity was too great on the unit, and nurses didn't want to be there," recalls Jill Fuller, RN, the hospital's chief nursing officer. A new organizational structure was needed. First, the nursing leadership was reorganized. The nurse manager who oversaw both the medical/surgical and obstetrics units was assigned to manage only the obstetrics unit. In 2001, a full-time manager was assigned to medical/surgical and assistant manager positions for both obstetrics and medical/surgical were eliminated. "That was the first change," notes Cindy Ruedebusch, RN, hospital resource nurse.

The medical/surgical nursing team studied the tasks a nurse had to perform in just the first hour of a shift. They found that paperwork was overwhelming and that nurses constantly were working around barriers or mending system breakdowns. The hunting and gathering for supplies, equipment, documents and people was endless. Communication breakdowns were common.

"The bottom line is we had an unhappy workforce," Fuller says. And, leaders observed, an unhappy workforce often leads to unhappy patients.

TEAM MEMBERS

- » Penny Eickholt, RN
- » Jill Fuller, RN
Chief Nursing Officer
- » Paul A. Hanson
CEO and President
- » Cindy Ruedebusch, RN
- » Shelly Turbak, RN
Medical/Surgical Director

At the same time, hospital leaders established productivity goals. It gave nurses a context for redesigning systems. “Our mantra was we’re going to do less with less,” Fuller says—meaning less of the non-patient care tasks that amounted to busywork.

With that mindset, the nurses led a medical/surgical redesign that ultimately changed the admissions process, care planning, medication administration, patient care documentation, information management systems, clinical procedure protocols, patient and family education and the discharge process.

PRINCIPLES OF PERFORMANCE EXCELLENCE

Creation of High-Reliability Culture

The change in organizational structure on medical/surgical unit was followed by several other changes. The nurses set out to change the care delivery model. The unit implemented a team-based model, with every nurse touching patients. Starting with a 10-bed pilot project in 2002, the charge nurse position was dissolved and replaced by a resource nurse. The primary role of the resource nurse was to be an admission partner to assist bedside nurses. “It decreased the work intensity around admissions,” Ruedebusch says. The pilot was successful and these changes in nursing roles were sustained. The key to success was letting frontline staff drive change. “There are four degrees of separation from myself and a nurse,” Hanson says. “The C-suite can make decisions...and think they are good for the unit, but without staff input and direction, we can be way off base.”

Reducing Process Variation

Moxie and technology helped the medical/surgical staff redesign processes around patient care documentation, supplies and equipment, medication administration and communication. “We blew up our old medical record,” Fuller says. A transition to an electronic health record allowed staff to redefine the patient record and eliminated redundancies, and made changes that enhanced patient care. For example, pharmacists create the patient’s electronic medication administration record, a task that had been done by nursing and unit secretaries.

It made no sense for nurses to conduct the requisite hunting and gathering expeditions for supplies and equipment. Over time, medical/surgical beds were converted to those with built-in scales. “We set up a standard so each room had a consistent set-up,” Fuller says. Rooms were fitted with “servers,” a special cupboard that can be stocked from the hallway and can be accessed from a patient’s room. Working with materials management, supplies are regularly restocked in this server. “Nurses also developed ‘grab and go’ bins that contain supplies for commonly performed procedures,” she says.

To improve efficiency and safety, medication administration was changed. Medications are in a locked drawer in the server in each patient room, so nurses can prepare medicines at the bedside without the distractions that come with preparing medicines at a central station. “Nurses used to experience up to seven interruptions before,” says Shelly Turbak, RN, medical/surgical director. “That’s very unsafe.” Now, pharmacy techs stock routine scheduled medicines in the server. A

unit-based pharmacist stocks urgently needed medicines following an order and flags the server cabinet to alert the bedside nurse of the replenishing. The medication administration record is pulled up on the wireless laptop in the room.

Several communication-related changes were made—among the most basic and most helpful to nurses has been the addition of walkie-talkies. “Instead of wandering around looking for help, we use walkies now,” says Penny Eickholt, RN. All of these changes allow nurses to spend more time with patients. “There is more education done,” Eickholt says. “Patients feel more prepared for discharge.”

CONTINUAL IMPROVEMENT

The team is continually improving the work environment and processes on the medical/surgical unit. Patient care documentation systems are modified on an ongoing basis to improve efficiency. New projects—including current implementation of bar code medication verification—are introduced with special attention to workload so productivity improvements are sustained and nurses can spend more time with patients. The hospital benefits too. For example, the reduction in paid nursing hours was possible because of work redesign efforts that decreased time nurses spent managing paperwork and inefficient systems. “We also have less overtime and less staff turnover which has improved our productivity” notes Fuller. “The staff on this unit spend more time in direct care and value-added activities and, as a result, are more productive.”