Fostering engagement and improvement through leadership at the gemba

Meredith Foxx
Lisa Yerian

Us

Meredith

Meredith Foxx

Executive Chief Nursing Officer

Cleveland Clinic

Lisa

Lisa Yerian, MD

Chief Improvement Officer

GI and Liver Pathology

Cleveland Clinic

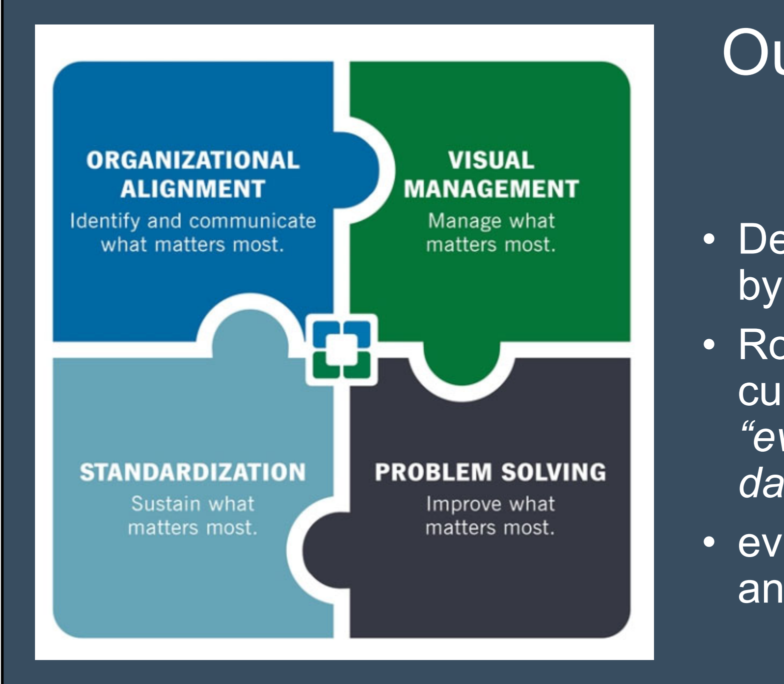
Why must healthcare change?

- Too expensive
- Safety and quality inadequate
- Poor access
- Global pandemic and staffing shortages
- Caregivers carry a tremendous burden

How?

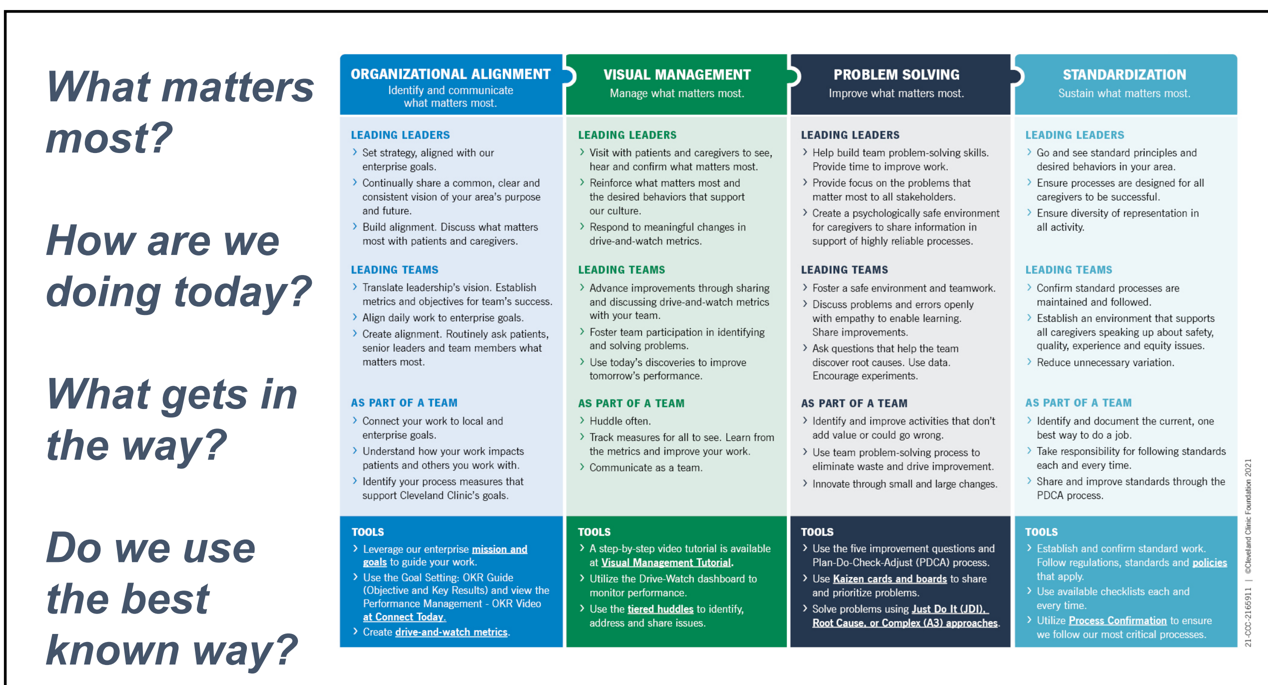
"Culture of Improvement"

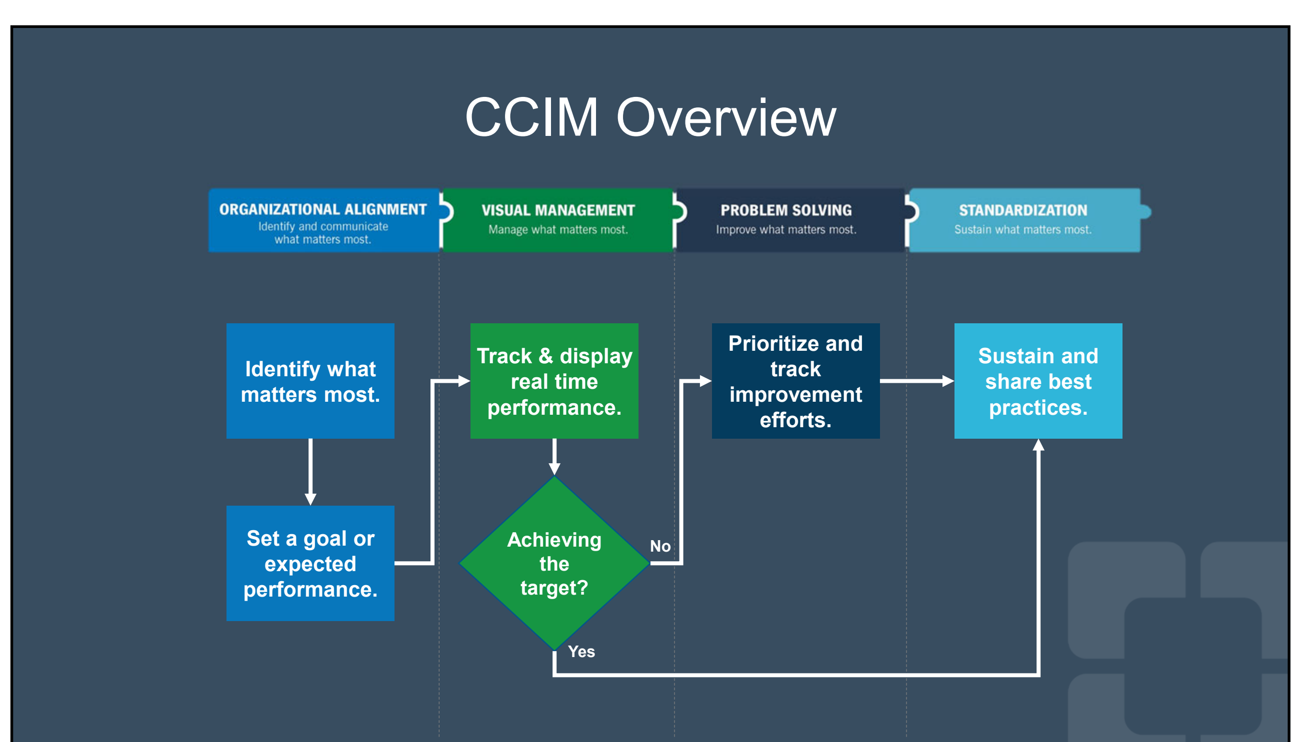
every caregiver capable, empowered and expected to make improvements every day



Our Improvement Model

- Developed, tested, refined by us
- Roadmap to create a culture of improvement – *"every caregiver, every day"*
- everywhere, for everyone and by everyone





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Lean Summit 2023

ORGANIZATIONAL ALIGNMENT

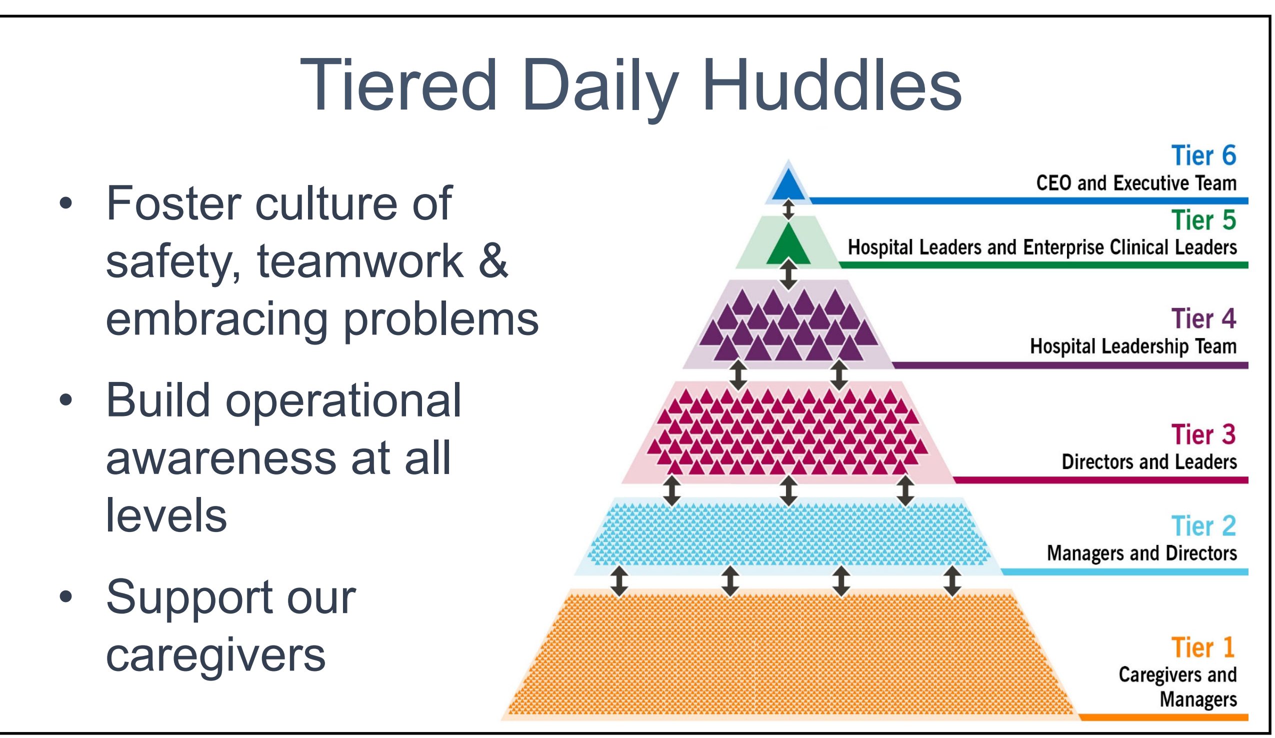
ORGANIZATIONAL ALIGNMENT
Identify and communicate what matters most.

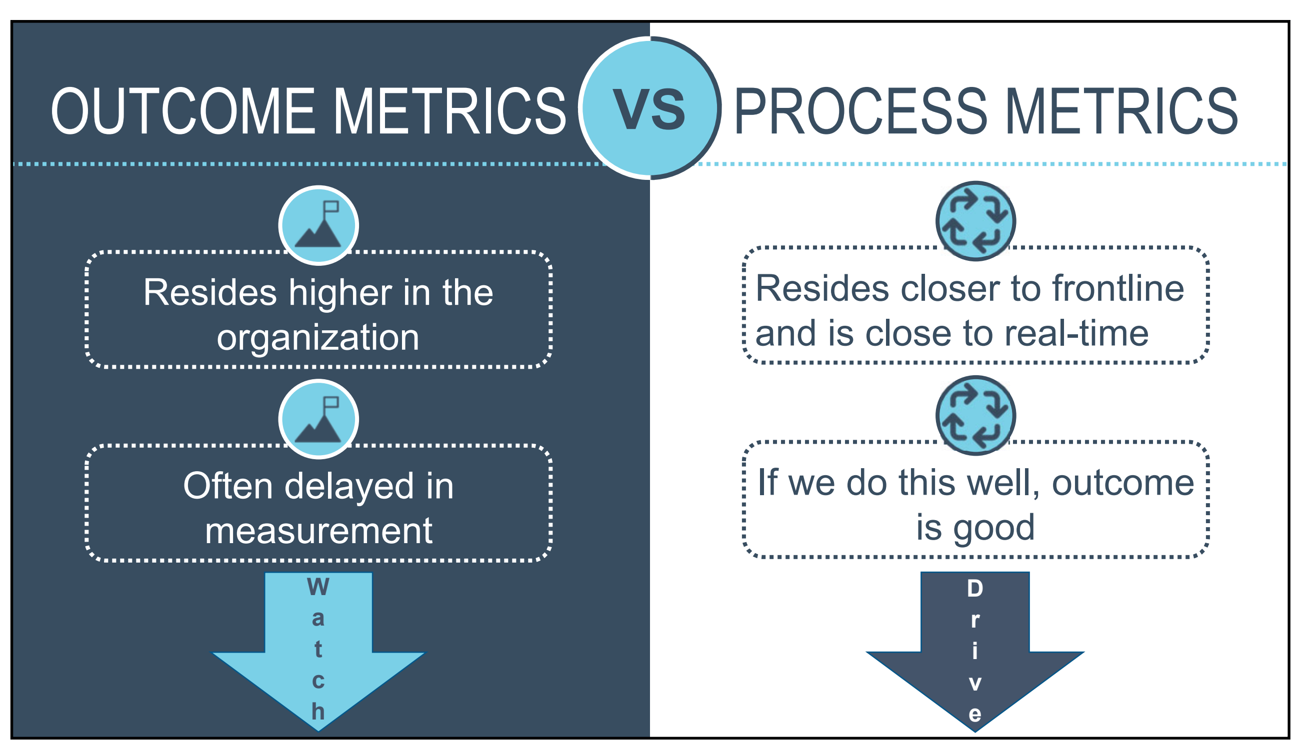
VISUAL MANAGEMENT
Manage what matters most.

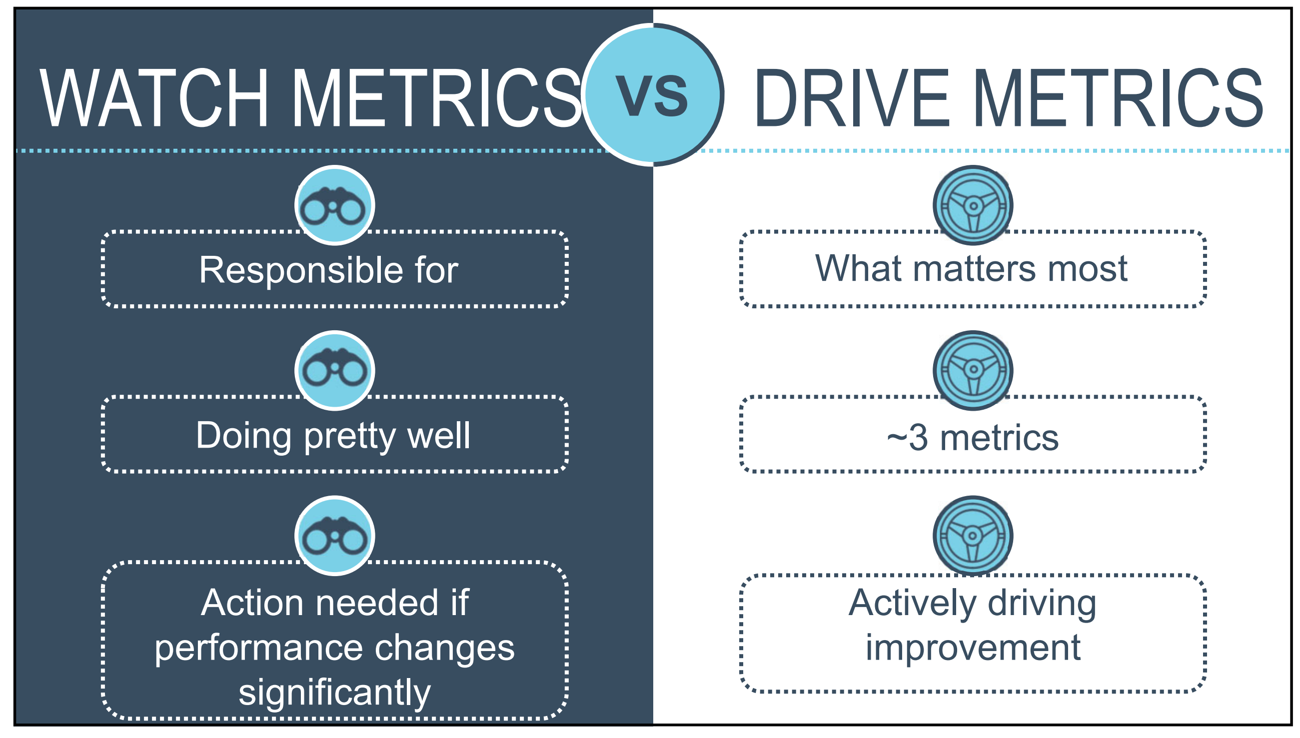
STANDARDIZATION
Sustain what matters most.

PROBLEM SOLVING
Improve what matters most.

ORGANIZATIONAL ALIGNMENT
Identify and communicate what matters most.




OUTCOME METRICS
VS
PROCESS METRICS
Resides higher in the organization
Often delayed in measurement
Watch
Resides closer to frontline and is close to real-time
If we do this well, outcome is good
Drive


WATCH METRICS
VS
DRIVE METRICS
Responsible for
Doing pretty well
Action needed if performance changes significantly
What matters most
~3 metrics
Actively driving improvement

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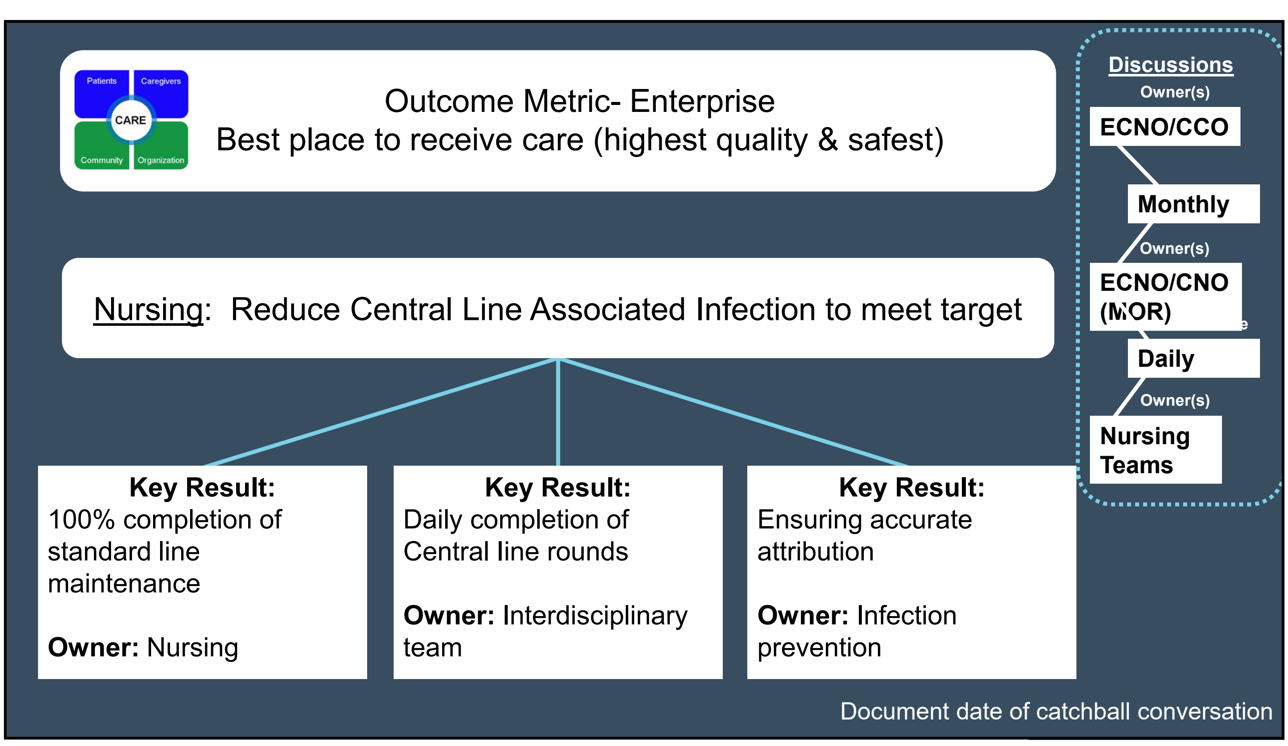
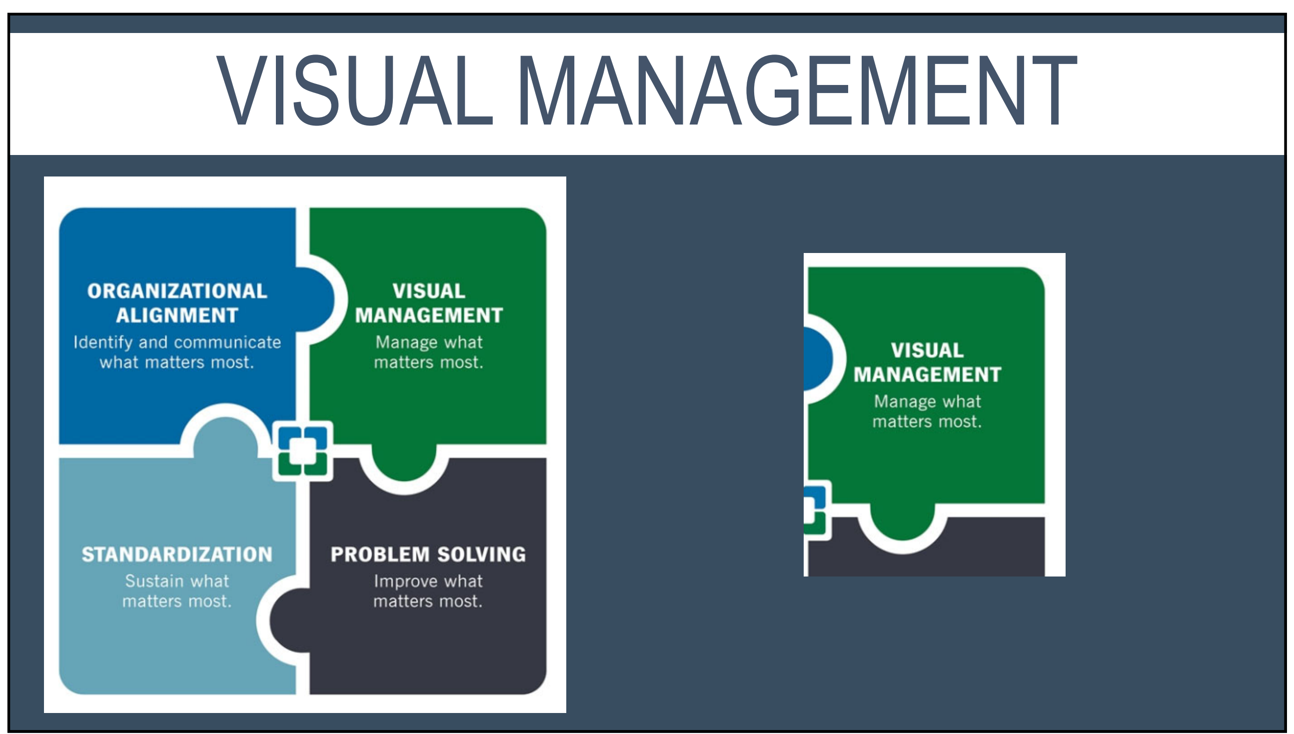

Patients
Caregivers
CARE
Community
Organization
Outcome Metric- Enterprise
Best place to receive care (highest quality & safest)
Nursing: Reduce Central Line Associated Infection to meet target
Key Result:
100% completion of standard line maintenance
Owner: Nursing
Key Result:
Daily completion of Central line rounds
Owner: Interdisciplinary team
Key Result:
Ensuring accurate attribution
Owner: Infection prevention
Discussions
Owner(s)
ECNO/CCO
Monthly
Owner(s)
ECNO/CNO (MOR)
Daily
Owner(s)
Nursing Teams
Document date of catchball conversation


VISUAL MANAGEMENT
ORGANIZATIONAL ALIGNMENT
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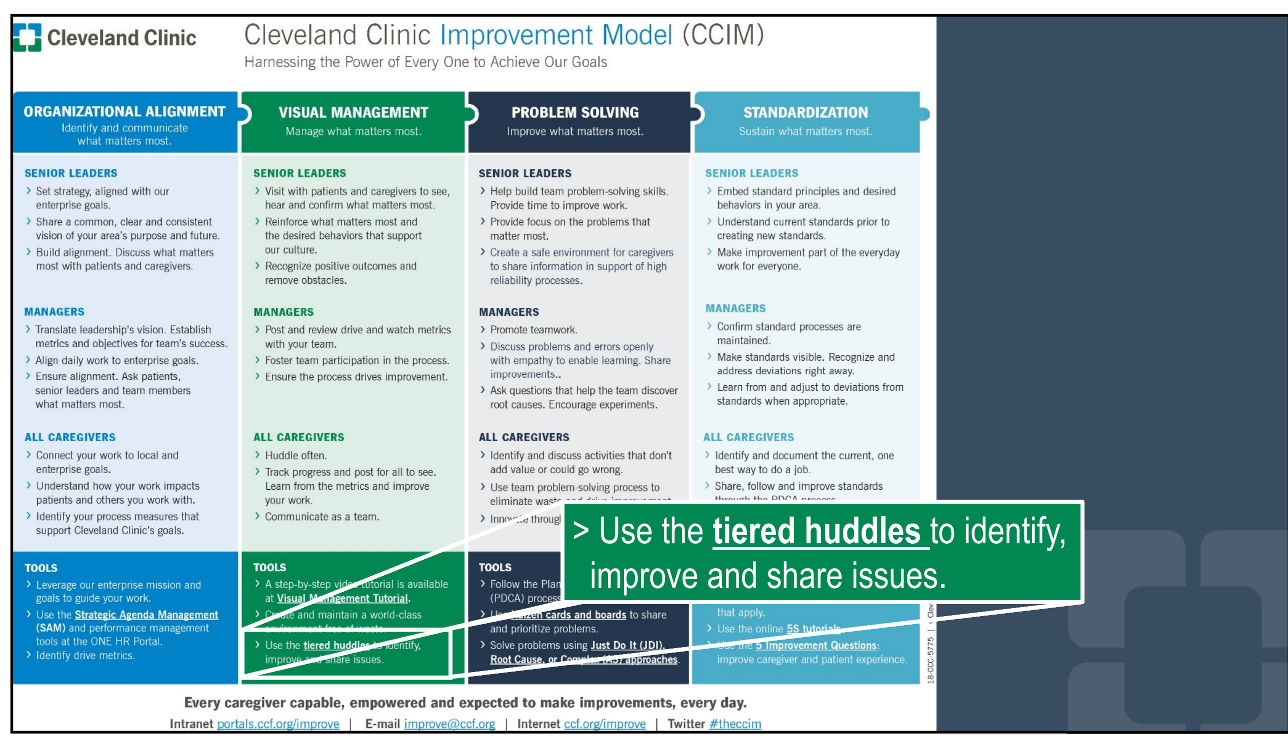

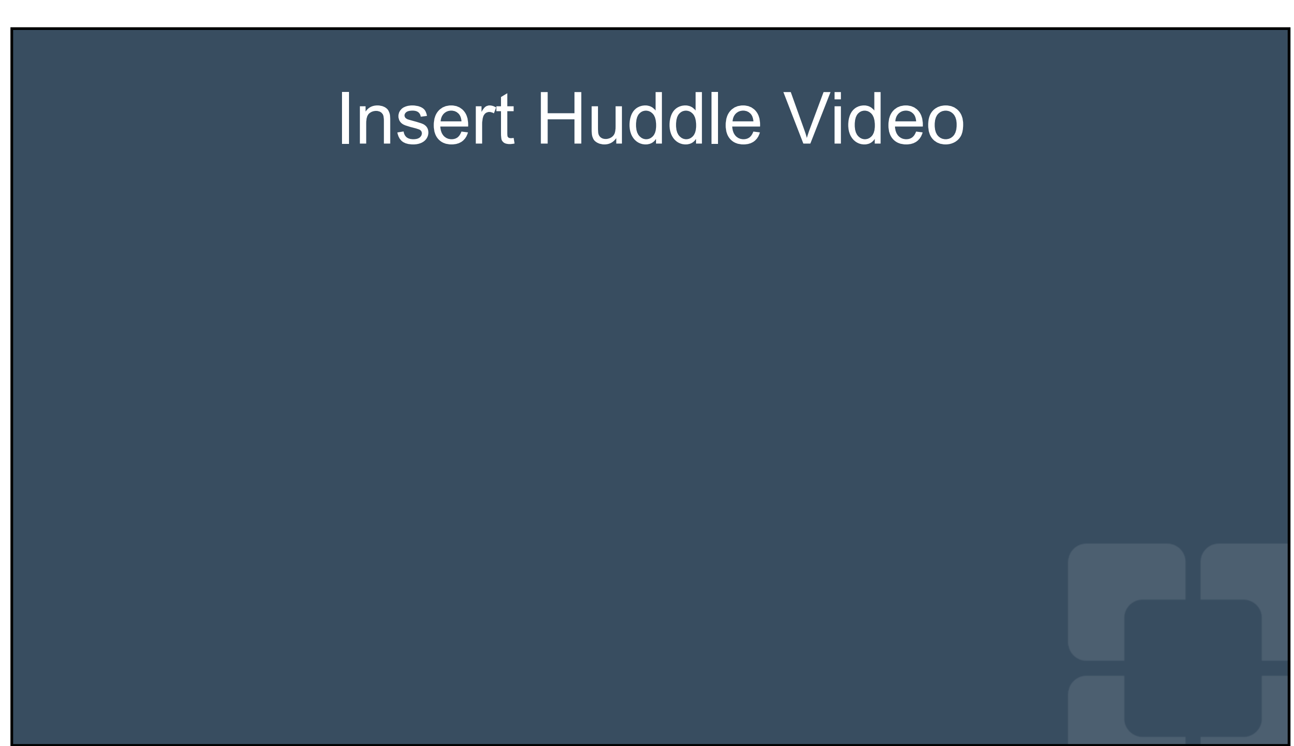

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Huddle Debrief

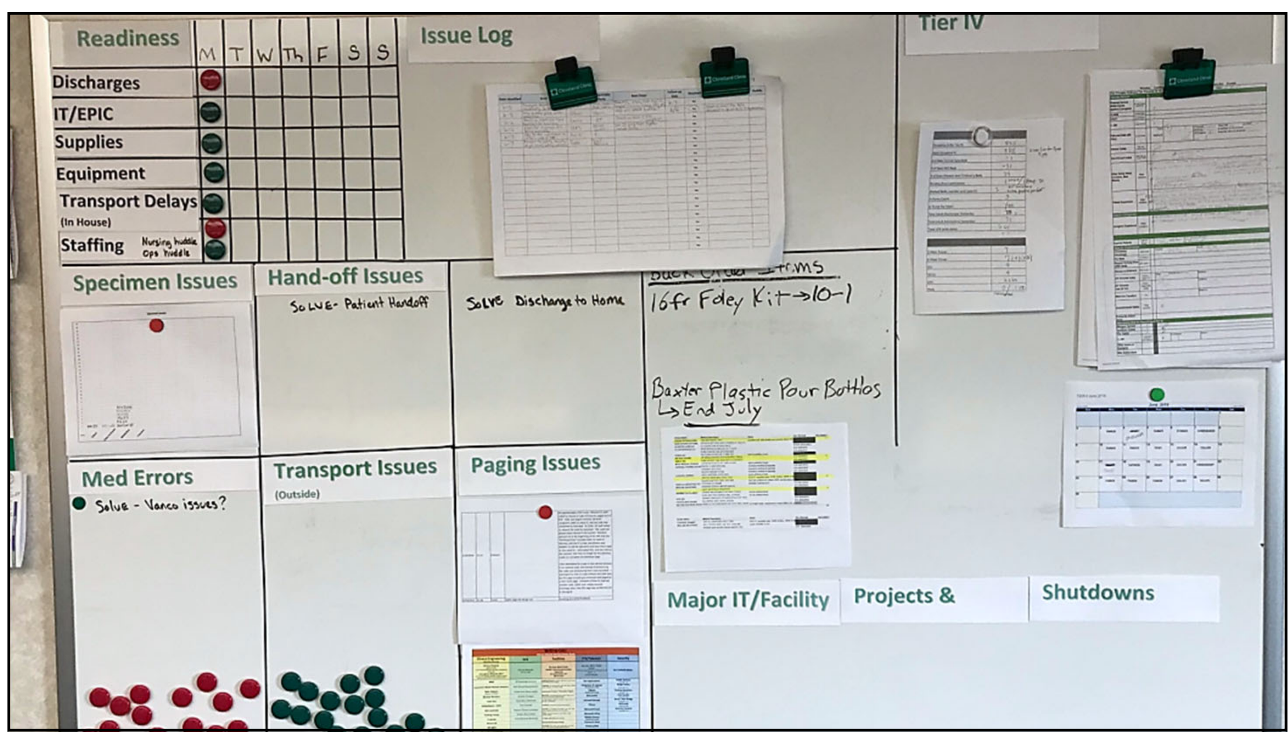
- What went well?
- How would you coach this team if you were Meredith?

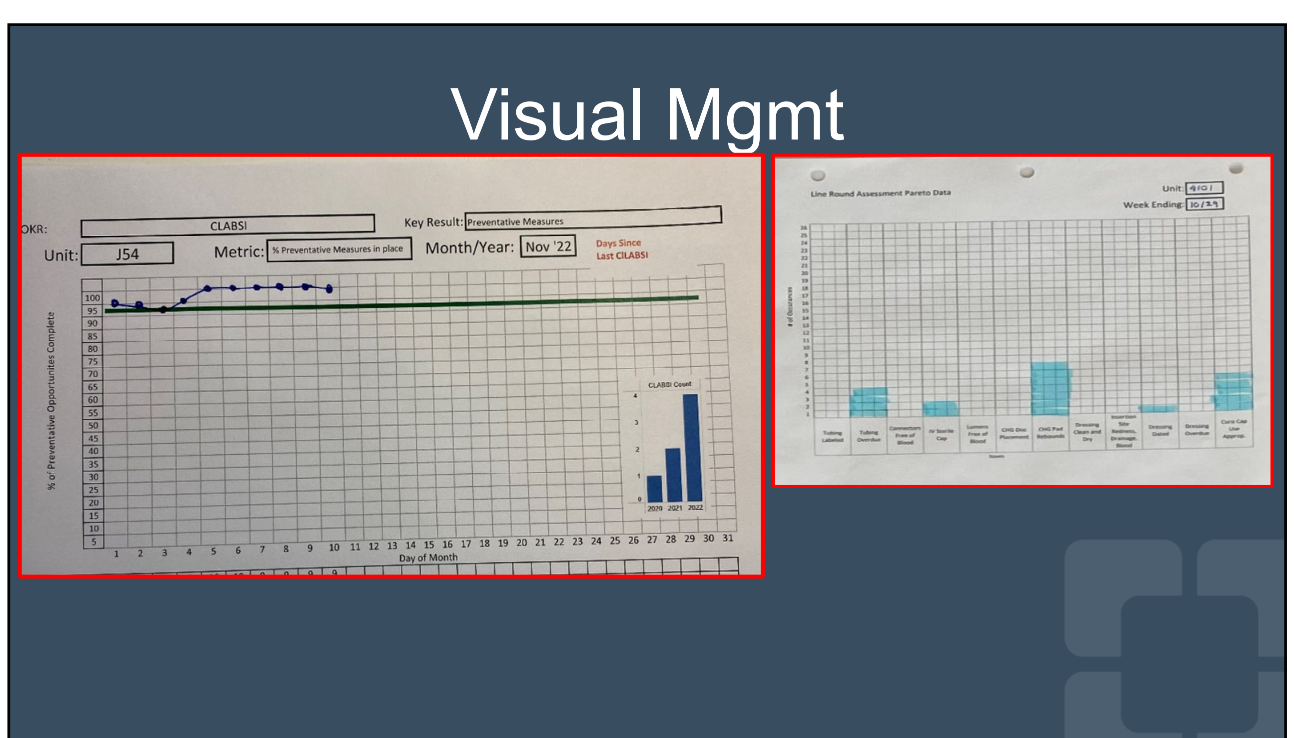
What makes visual mgmt. Ideal?

- What matters most- OKRs
- How are we doing today- Professional Practice Model huddle board
- Who are we taking care of
  - What is current state: patient volume/occupancy

When I don't see it

- Explicitly ask:
- What are you and the team focused on?
- How do you know if you are doing well or not?
- What is the biggest opportunity for improvement?


Readiness
M T W Th F S S
Discharges
IT/EPIC
Supplies
Equipment
Transport Delays
(In House)
Staffing
Nursing huddle
Ops huddle
Issue Log
Tier IV
Specimen Issues
Hand-off Issues
SOLVE- Patient Handoff
SOLVE Discharge to Home
16fr Foley Kit → 10-1
Baxter Plastic Pour Bottles
↳ End July
Med Errors
Solve - Vanco issues?
Transport Issues
(Outside)
Paging Issues
Major IT/Facility
Projects &
Shutdowns


Visual Mgmt
OKR:
CLABSI
Key Result:
Preventative Measures
Unit:
J54
Metric:
% Preventative Measures in place
Month/Year:
Nov '22
Days Since
Last CLABSI
% of Preventative Opportunites Complete
CLABSI Count
2020 2021 2022
Day of Month
Line Round Assessment Pareto Data
Unit:
Week Ending:
# of Occurances
Tubing Labeled
Tubing Overdue
Connectors Free of Blood
IV Sterile Cap
Lumens Free of Blood
CHG Disc Placement
CHG Pad Reboundt
Dressing Clean and Dry
Insertion Site Redness, Drainage, Blood
Dressing Dated
Dressing Overdue
Curo Cap Line Approp.
Issues

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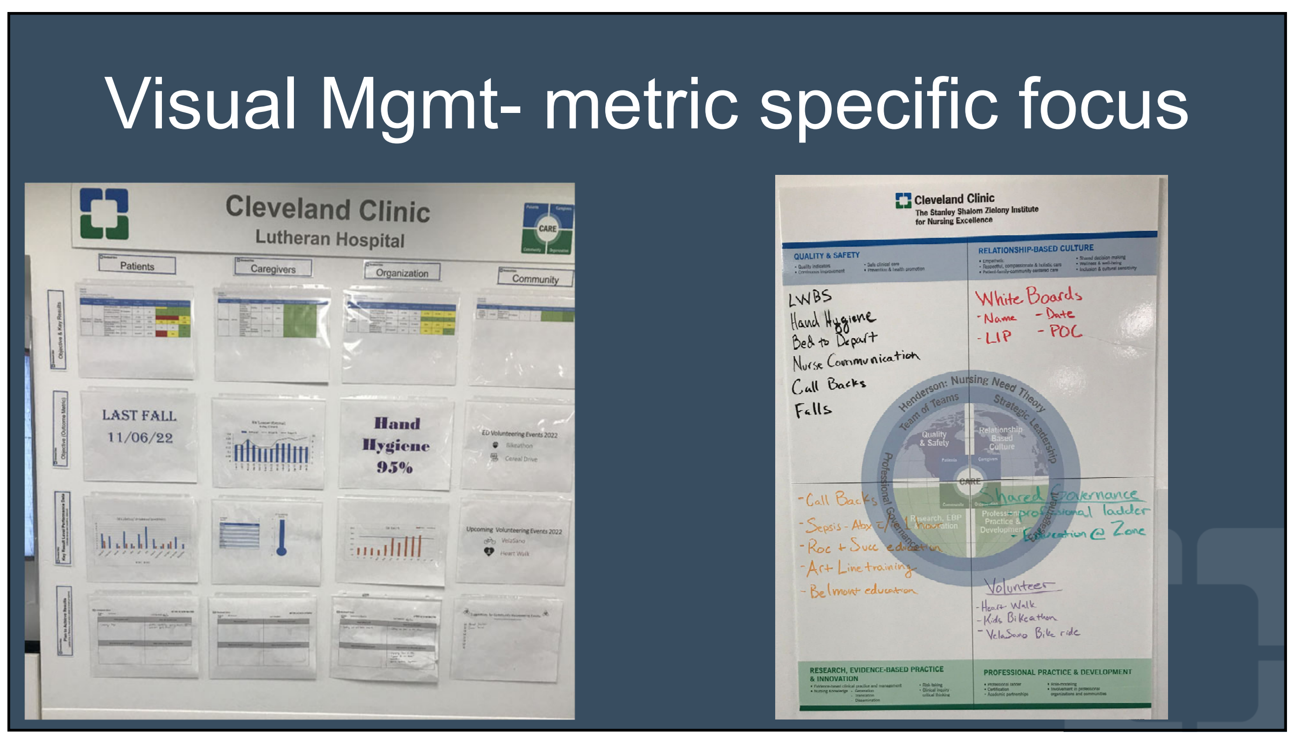
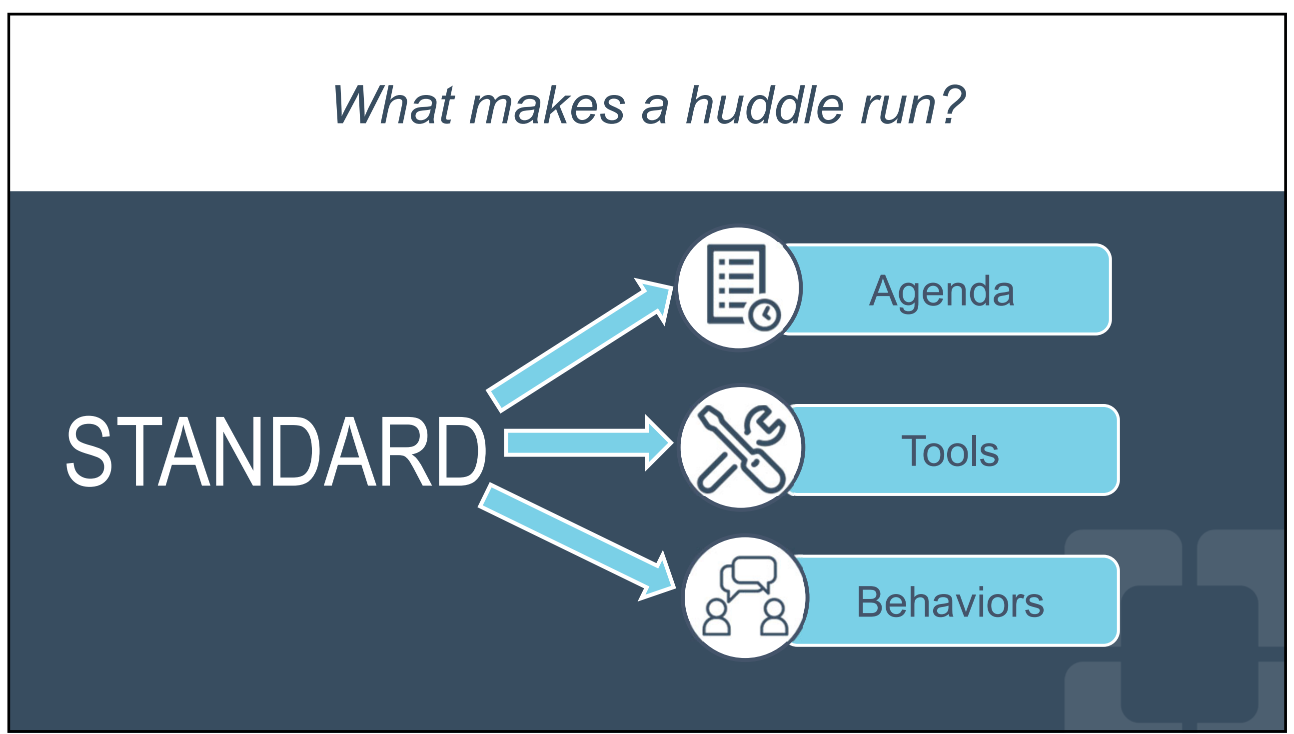

Visual Mgmt- metric specific focus
Cleveland Clinic
Lutheran Hospital
Patients
Caregivers
Organization
Community
LAST FALL
11/06/22
Hand
Hygiene
95%
Cleveland Clinic
The Stanley Shalom Zielony Institute for Nursing Excellence
QUALITY & SAFETY
RELATIONSHIP-BASED CULTURE
LWBS
Hand Hygiene
Bed to Depart
Nurse Communication
Call Backs
Falls
White Boards
- Name
- Date
- LIP
- POC
- Call Backs
- Roc + Succ education
- Art Line training
- Belmont education
Volunteer
- Kids Bikeathon
- VeloSano Bike ride
RESEARCH, EVIDENCE-BASED PRACTICE & INNOVATION
PROFESSIONAL PRACTICE & DEVELOPMENT


What makes a huddle run?
STANDARD
Agenda
Tools
Behaviors

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CLABSI

- Type of line/how long has it been in?
- Type of organism
- Likely source:
  - *Insertion* – occurred within 7 days of a new line
  - *Duration/Location* – site selected or duration of time in that location (>14 days) may have caused the infection
  - *Maintenance* – CHG bath documented daily? Dressing integrity maintained? Oozing at site?
  - *Access* – Adherence to scrub the hub/use of Curos caps
  - *Definition* – infection could likely be sourced elsewhere

CAUTI

- Duration of Foley
- Type of Organism
- Culture appropriate to send – symptoms present of fever, pain, leukocytosis? (Y/N)
- UA sent first to confirm bacteria present?
- Foley changed prior to sending the culture
- Proper sampling supplies used? - vaccutainer for culture (Y/N)

Falls

- Patient assessed at a high fall risk? (Y/N)
  - If no – was this the appropriate assessment
- Fall assisted? (Y/N)
- Physiologic fall? (Y/N)
- Injury sustained? (Y/N)
- If high risk, were the following interventions in place
  - Bed Alarm and/or Chair Alarm
  - BR Assistance "within arm's reach"
  - My Safety Plan complete
  - Hourly Rounding
  - How long to respond to the call light or bed alarm?

Code Blue

- Significant safety issue?
- Patient monitored? (Y/N)
  - If yes, changes to telemetry, pulse ox, RR prior

COACHING QUESTIONS

Enterprise Tier 5 Huddle

how are we doing *today?*

Tier Huddle | Definitions

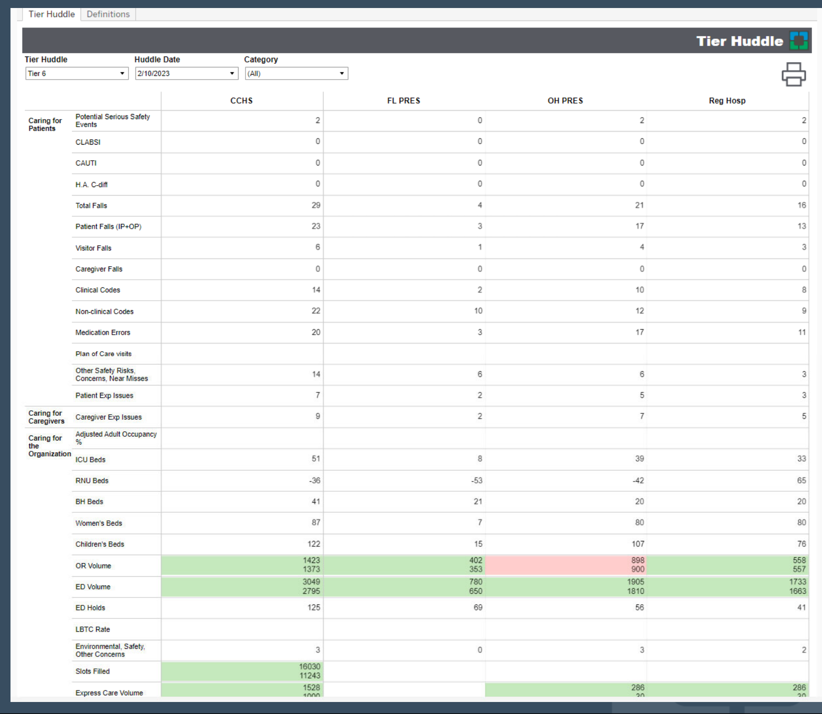
Tier Huddle

Tier Huddle: Tier 5 | Huddle Date: 2/10/2023 | Category: (All)

		CCHS	FL PRES	OH PRES	Reg Hosp	ACMC	AG	ALL INST	AV	EU	FHCs	FV	HL	LU	MC	ME	MM	MMC	SP	UN	IR	MN	MS	MT	WST	CCL	CCAD
Caring for Patients	Potential Serious Safety Events	2	0	2	2	0	0		0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
	CLABSI	0	0	0	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	CAUTI	0	0	0	0	0	0		0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	H.A. C-diff	0	0	0	0	0	0		0	0		0	0	0	0	0	0	0		0	0	0	0	0	0	0	
	Total Falls	29	4	21	16	1	1		1	1	3	0	4	2	5	1	0	2	2	1	1	1	0	1	1	1	
	Patient Falls (IP+OP)	23	3	17	13	1	1		0	0	2	0	3	2	4	1	0	2	2	1	1	1	0	1	0	1	
	Visitor Falls	6	1	4	3	0	0		1	1	1	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	
	Caregiver Falls	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Clinical Codes	14	2	10	8	0	1		0	0	0	2	1	0	2	0	1	1	0	2	1	0	1	0	0	2	
	Non-clinical Codes	22	10	12	9	0	0		0	0	0	2	1	1	3	0	1	3	1	0	1	3	1	3	2	0	
	Medication Errors	20	3	17	11	0	0		0	0	0	5	2	0	6	0	1	1	1	1	1	1	1	0	0	0	
	Plan of Care visits					98% 85%	87% 85%		94% 85%	93% 85%		85% 85%	89% 85%	85% 85%	86% 85%	88% 85%	82% 85%	83% 85%	68% 85%	93% 85%	90% 85%	85.5% 85%	88.8% 85%	94% 85%	89% 85%	92% 85%	81% 85%
	Other Safety Risks, Concerns, Near Misses	14	6	6	3	0	0		0	0	0	2	0	0	3	0	1	0	0	0	4	0	1	0	1	2	
	Patient Exp Issues	7	2	5	3	0	0		0	0	0	1	1	0	2	0	0	0	1	0	1	0	1	0	0	0	
Caring for Caregivers	Caregiver Exp Issues	9	2	7	5	0	0		0	0	0	2	1	0	2	0	0	2	0	0	0	0	1	1	0	0	
Caring for the Organization	Adjusted Adult Occupancy %					86% 90%	94% 90%		86% 90%	91% 90%		94% 90%	93% 0%	84% 90%	96% 90%	88% 90%	83% 90%	98% 90%	93% 90%	60% 90%	83% 90%	95% 90%	89% 90%	98% 90%	97% 90%	78.7% 90%	90% 0%
	ICU Beds	51	8	39	33	3	4		3	2		-2	5	0	6	0	3	5	6	4	2	0	3	2	1	0	4
	RNU Beds	-36	-53	-42	65	19	19		5	-8		3	-13	-6	-107	15	5	0	3	23	32	-12	2	-9	-66	27	32
	BH Beds	41	21	20	20	8	1			1		-1		8			3				21						
	Women's Beds	87	7	80	80		25					14	23		0			16		2	4	-4		7			
	Children's Beds	122	15	107	76		12					25	27		31			12		0	0	4		11			
	OR Volume	1423 1373	402 353	898 900	558 557	44 32	95 92		46 58	28 15		82 78	59 82	24 24	340 343	49 41	46 44	29 37	18 28	38 26	83 52	72 77	15 25	49 60	183 139	27 22	96 98
	ED Volume	3049 2795	780 650	1905 1810	1733 1663	77 81	304 321	185 179	129 140	138 126		214 219	236 184	102 96	172 147	83 77	120 117	144 135	100 87	86 80	165 159	110 97	120 88	229 190	156 116		179 156
	ED Holds	125	69	56	41	0	6		2	6		8	5	1	15	0	5	4	2	2	0	17	2	9	41		
	LBTC Rate					0% 4.5%	4.6% 4.5%	1.1% 4.5%	0% 4.1%	5.1% 4.5%		14.5% 4.5%	4.2% 4.2%	3.9% 4.2%	18.6% 4.5%	1.2% 4%	13.3% 4.5%	8.3% 4.2%	5% 4.5%	6% 4.5%	1.8% 4.3%	0% 4.5%	1.6% 4.2%	1.7% 4.5%	1.9% 4.5%		1% 0%
	Environmental, Safety, Other Concerns	3	0	3	2	0	0		1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	
	Slots Filled	16030 11243									16030 11243																
	Express Care Volume	1528		286	286			1242										225		61							

Enterprise Tier 6 Huddle

how are we doing *today?*

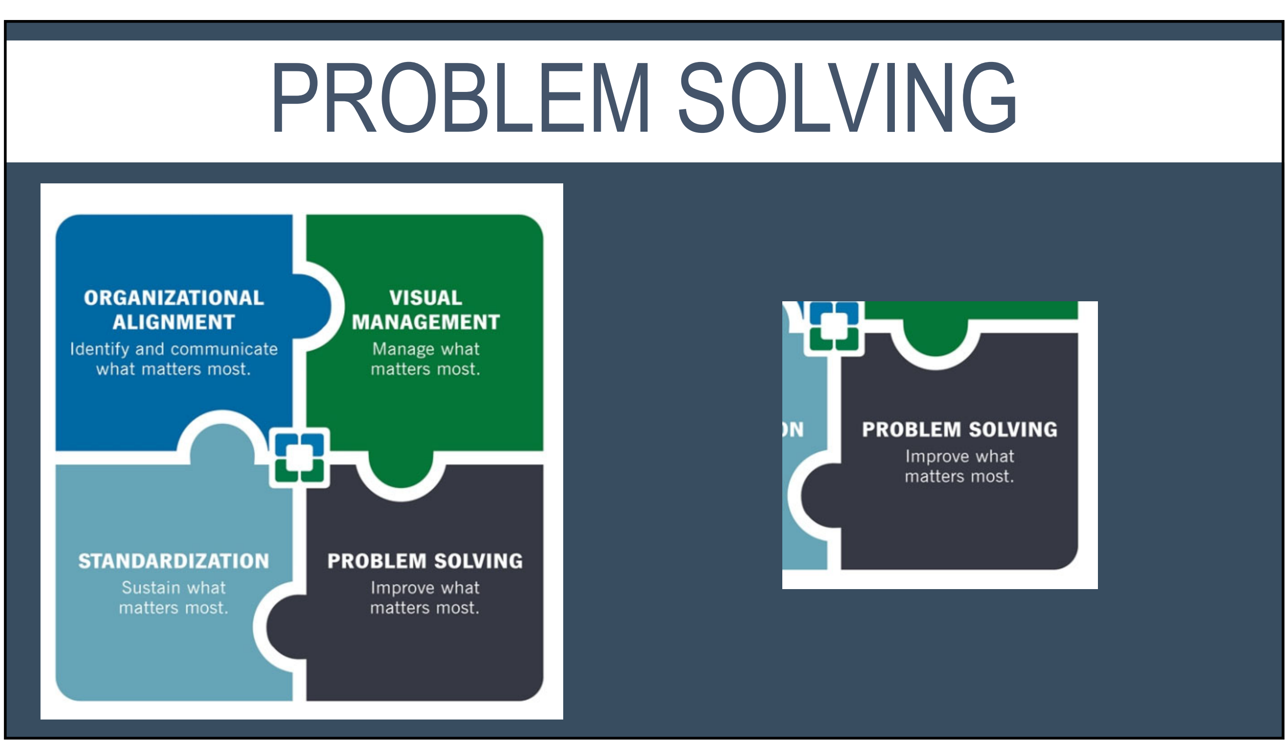


Tier Huddle | Definitions

Tier Huddle

Tier Huddle: Tier 6 | Huddle Date: 2/10/2023 | Category: (All)

		CCHS	FL PRES	OH PRES	Reg Hosp
Caring for Patients	Potential Serious Safety Events	2	0	2	2
	CLABSI	0	0	0	0
	CAUTI	0	0	0	0
	H.A. C-diff	0	0	0	0
	Total Falls	29	4	21	16
	Patient Falls (IP+OP)	23	3	17	13
	Visitor Falls	6	1	4	3
	Caregiver Falls	0	0	0	0
	Clinical Codes	14	2	10	8
	Non-clinical Codes	22	10	12	9
	Medication Errors	20	3	17	11
	Plan of Care visits				
	Other Safety Risks, Concerns, Near Misses	14	6	6	3
	Patient Exp Issues	7	2	5	3
Caring for Caregivers	Caregiver Exp Issues	9	2	7	5
Caring for the Organization	Adjusted Adult Occupancy %				
	ICU Beds	51	8	39	33
	RNU Beds	-36	-53	-42	65
	BH Beds	41	21	20	20
	Women's Beds	87	7	80	80
	Children's Beds	122	15	107	76
	OR Volume	1423 1373	402 353	898 900	558 557
	ED Volume	3049 2795	780 650	1905 1810	1733 1663
	ED Holds	125	69	56	41
	LBTC Rate				
	Environmental, Safety, Other Concerns	3	0	3	2
	Slots Filled	16030 11243			
	Express Care Volume	1528		286	286


PROBLEM SOLVING
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Sustain what matters most.
PROBLEM SOLVING
Improve what matters most.
PROBLEM SOLVING
Improve what matters most.

WHAT MATTERS MOST?
We can't work on everything
453 things to improve?
Focus on a crucial few
Which metrics are most important?

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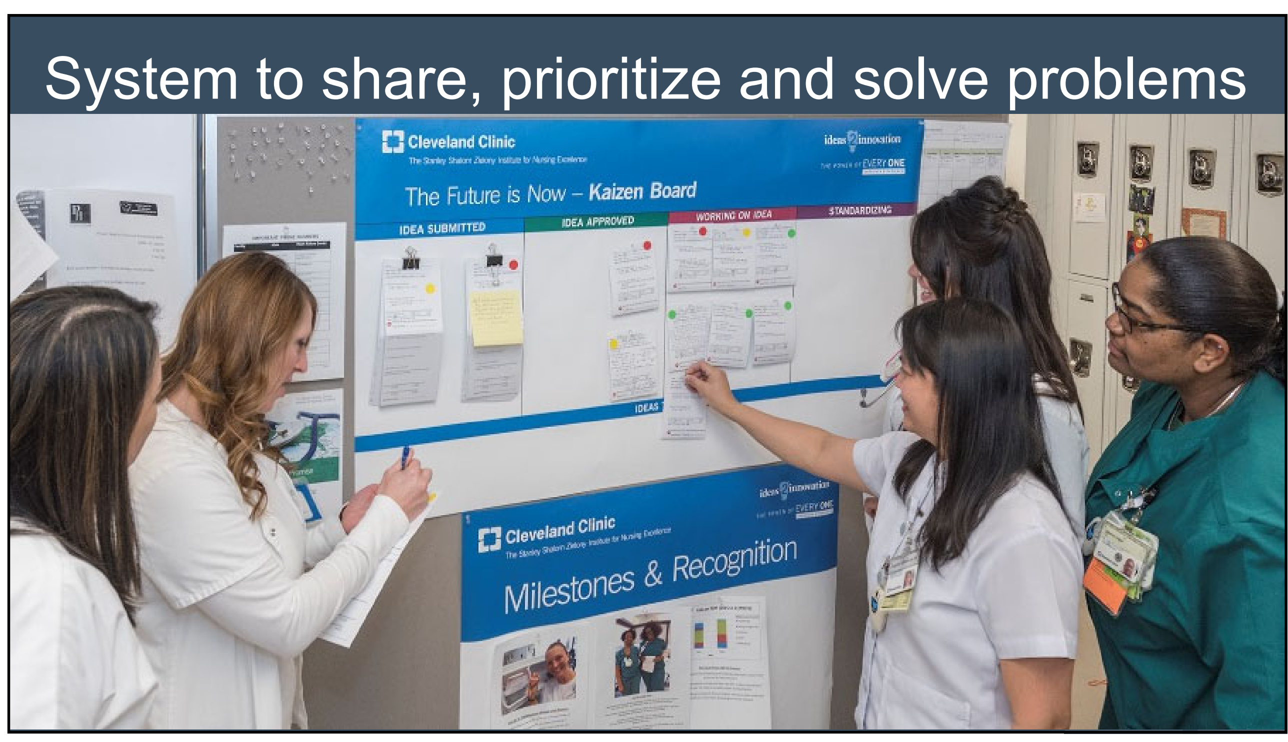
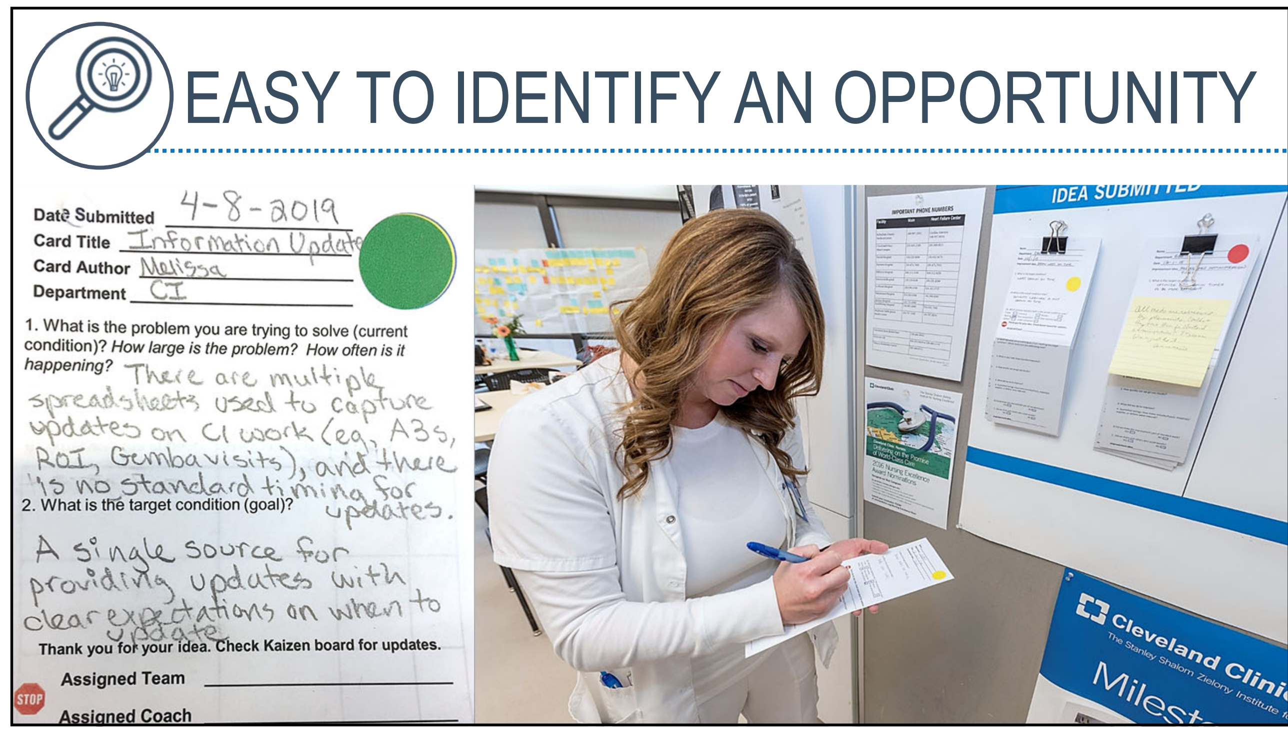

System to share, prioritize and solve problems
Cleveland Clinic
The Future is Now – Kaizen Board
IDEA SUBMITTED
IDEA APPROVED
WORKING ON IDEA
STANDARDIZING
IDEAS
Cleveland Clinic
Milestones & Recognition


EASY TO IDENTIFY AN OPPORTUNITY
Date Submitted 4-8-2019
Card Title Information Update
Card Author Melissa
Department CI
1. What is the problem you are trying to solve (current condition)? How large is the problem? How often is it happening?
There are multiple spreadsheets used to capture updates on CI work (eg, A3s, ROI, Gemba visits), and there is no standard timing for updates.
2. What is the target condition (goal)?
A single source for providing updates with clear expectations on when to update.
Thank you for your idea. Check Kaizen board for updates.
Assigned Team
Assigned Coach
IDEA SUBMITTED
Cleveland Clinic
The Stanley Shalom Zielony Institute
Milest

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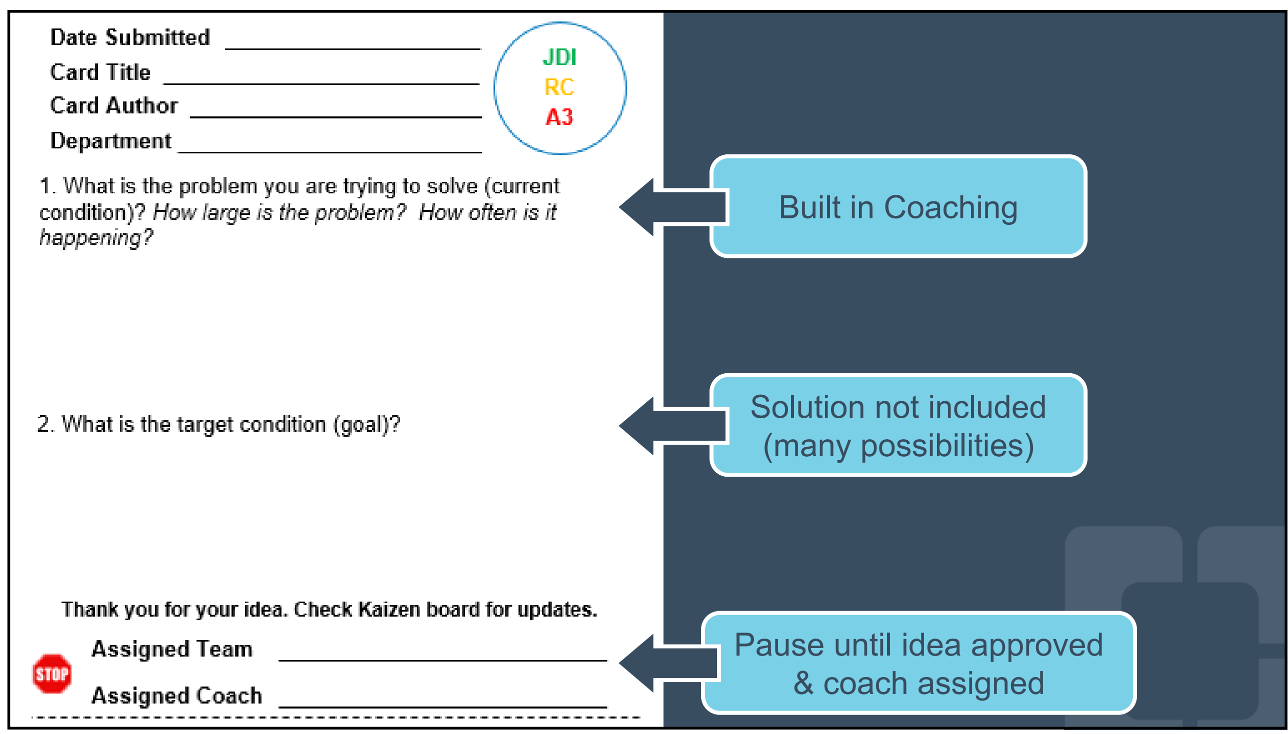

Problem Solving Approaches

Understanding of Problem	Problem is well understood Root cause & solution are known	Problem is somewhat understood Root cause & solution are unknown	Problem is not understood Root cause(s) & solution are unknown
Effort to Address Problem	Low	Medium	High
Name	Just Do It (JDI)	Root Cause	Complex (A3)
Visual	Green Dot	Yellow Dot	Red Dot

Collaboration - Identify stakeholders impacted by the problem & involve them in the improvement work

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Discharge Order to Actual Discharge

Owner: Clarke/Malchow

Background & Target: At Cleveland Clinic Martin South, in 2021 we averaged 45% of our patients being discharged from the Observation Unit within 150 minutes after the discharge order is placed. We want to increase this percentage to 70% by December 31, 2021

Visual Management

Tracking data for why Patients not discharged Began 1/14/21

Completed / In Progress / Next Steps (Task Plan)

- Collect data on average discharge time for all observation patients by unit..
- Tracking why observations patients are not discharged at 150 minutes post order via pareto analysis.
- Working on communication plan for patients to have ride readily available when discharge plan is known.
- Process Map process from Hospitalist discharge of Observation patient to actual discharge.

Barriers / Concerns / Risks

- Providers placing order to allow Case Management to work on placement and patient not actually ready for discharge.
- Physical Therapist not dedicated to Observation patients .
- 42% of Observation patients admitted to units outside of Observation Unit.
- ANM's taking full assignment leaving nobody to handle flow on the unit.
- Nurses on unit were not aware of a goal.
- Patient's don't have rides timely when ready to discharge.

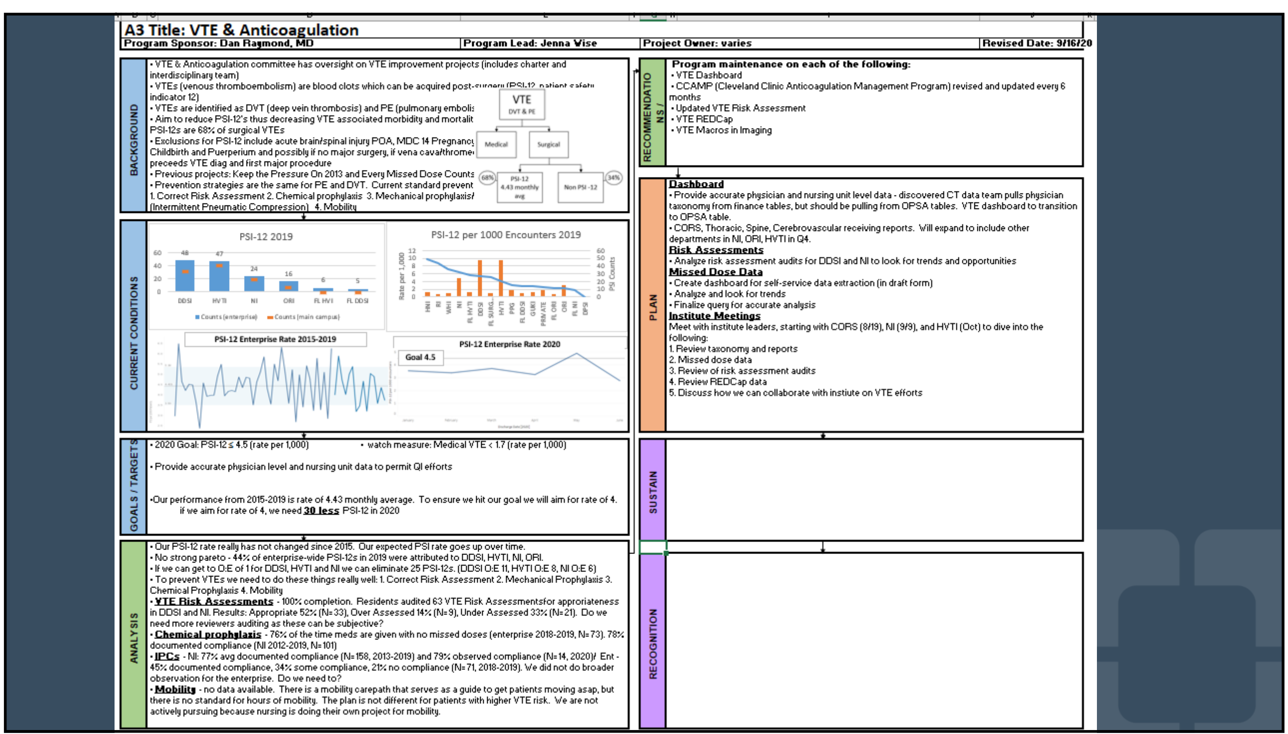
Decisions / Escalations

- Need a goal set by team they would like to reach with agreement by leadership.
- Discussion with Lead Hospitalist on limiting discharge order placement prior to patient ready (only put in d/c order early for complicated discharge patients.
- Drive to have Observation patients admitted to Observation Unit if beds are available.

On track | Not on track

Black Text Completed | Blue Text In Process

J F M A M J J A S O N D



A3 Title: VTE & Anticoagulation

Program Sponsor: Dan Raymond, MD | **Program Lead: Jenna Vise** | **Project Owner: varies** | **Revised Date: 9/16/20**

BACKGROUND

- VTE & Anticoagulation committee has oversight on VTE improvement projects (includes charter and interdisciplinary team)
- VTEs (venous thromboembolism) are blood clots which can be acquired post-surgery (PSI-12, patient safety indicator 12)
- VTEs are identified as DVT (deep vein thrombosis) and PE (pulmonary embolis
- Aim to reduce PSI-12's thus decreasing VTE associated morbidity and mortalit PSI-12s are 68% of surgical VTEs
- Exclusions for PSI-12 include acute brain/spinal injury POA, MDC 14 Pregnancy Childbirth and Puerperium and possibly if no major surgery, if vena cava/throme preceeds VTE diag and first major procedure
- Previous projects: Keep the Pressure On 2013 and Every Missed Dose Counts
- Prevention strategies are the same for PE and DVT. Current standard prevent 1. Correct Risk Assessment 2. Chemical prophylaxis 3. Mechanical prophylaxis/ (Intermittent Pneumatic Compression) 4. Mobility

CURRENT CONDITIONS

GOALS / TARGETS

- 2020 Goal: PSI-12 ≤ 4.5 (rate per 1,000)
- watch measure: Medical VTE < 1.7 (rate per 1,000)
- Provide accurate physician level and nursing unit data to permit QI efforts
- Our performance from 2015-2019 is rate of 4.43 monthly average. To ensure we hit our goal we will aim for rate of 4. if we aim for rate of 4, we need **30 less** PSI-12 in 2020

ANALYSIS

- Our PSI-12 rate really has not changed since 2015. Our expected PSI rate goes up over time.
- No strong pareto - 44% of enterprise-wide PSI-12s in 2019 were attributed to DDSI, HVTI, NI, ORI.
- If we can get to O:E of 1 for DDSI, HVTI and NI we can eliminate 25 PSI-12s. (DDSI O:E 11, HVTI O:E 8, NI O:E 6)
- To prevent VTEs we need to do these things really well: 1. Correct Risk Assessment 2. Mechanical Prophylaxis 3. Chemical Prophylaxis 4. Mobility
- **VTE Risk Assessments** - 100% completion. Residents audited 63 VTE Risk Assessmentsfor approriateness in DDSI and NI. Results: Appropriate 52% (N=33), Over Assessed 14% (N=9), Under Assessed 33% (N=21). Do we need more reviewers auditing as these can be subjective?
- **Chemical prophylaxis** - 76% of the time meds are given with no missed doses (enterprise 2018-2019, N=73). 78% documented compliance (NI 2012-2019, N=101)
- **IPCs** - NI: 77% avg documented compliance (N=158, 2013-2019) and 79% observed compliance (N=14, 2020)/ Ent - 45% documented compliance, 34% some compliance, 21% no compliance (N=71, 2018-2019). We did not do broader observation for the enterprise. Do we need to?
- **Mobility** - no data available. There is a mobility carepath that serves as a guide to get patients moving asap, but there is no standard for hours of mobility. The plan is not different for patients with higher VTE risk. We are not actively pursuing because nursing is doing their own project for mobility.

RECOMMENDATIONS /

Program maintenance on each of the following:

- VTE Dashboard
- CCAMP (Cleveland Clinic Anticoagulation Management Program) revised and updated every 6 months
- Updated VTE Risk Assessment
- VTE REDCap
- VTE Macros in Imaging

PLAN

Dashboard

- Provide accurate physician and nursing unit level data - discovered CT data team pulls physician taxonomy from finance tables, but should be pulling from OPSA tables. VTE dashboard to transition to OPSA table.
- CORS, Thoracic, Spine, Cerebrovascular receiving reports. Will expand to include other departments in NI, ORI, HVTI in Q4.

Risk Assessments

- Analyze risk assessment audits for DDSI and NI to look for trends and opportunities

Missed Dose Data

- Create dashboard for self-service data extraction (in draft form)
- Analyze and look for trends
- Finalize query for accurate analysis

Institute Meetings

Meet with institute leaders, starting with CORS (8/19), NI (9/9), and HVTI (Oct) to dive into the following:

1. Review taxonomy and reports
2. Missed dose data
3. Review of risk assessment audits
4. Review REDCap data
5. Discuss how we can collaborate with instiute on VTE efforts

SUSTAIN

RECOGNITION

STANDARDIZATION

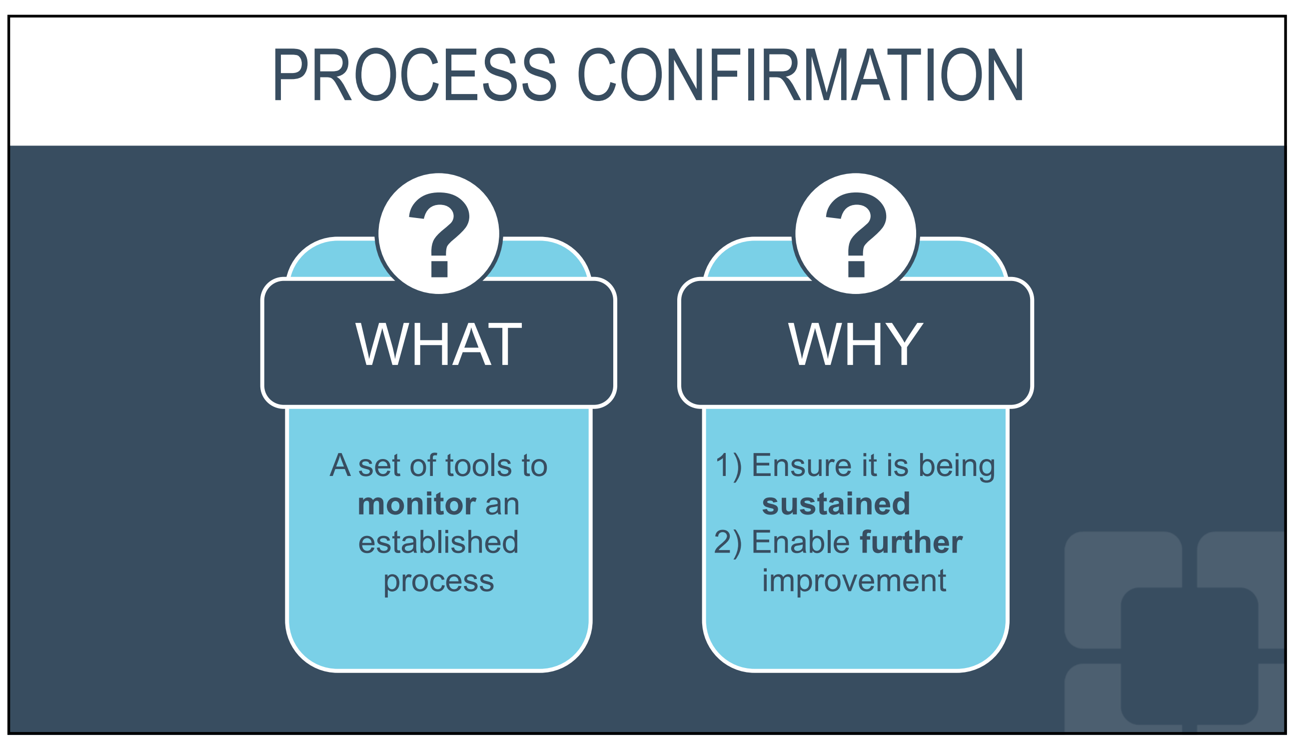
ORGANIZATIONAL ALIGNMENT
Identify and communicate what matters most.

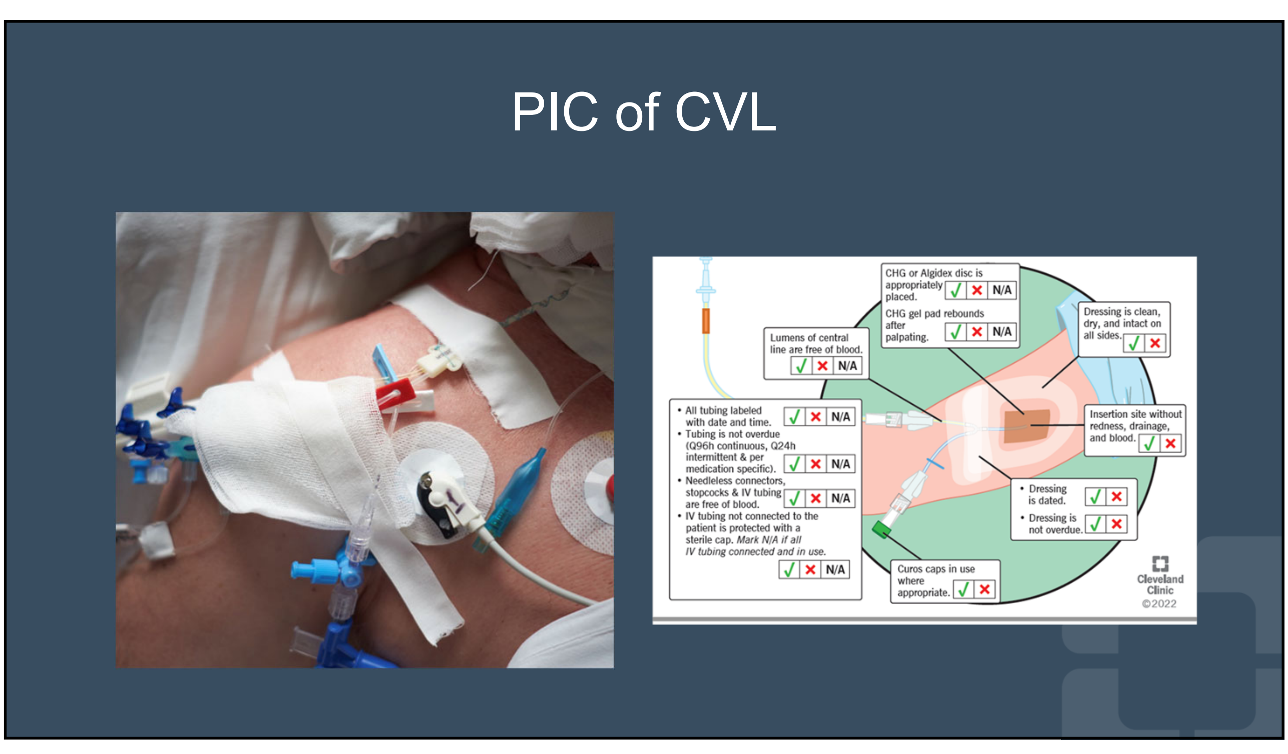
VISUAL MANAGEMENT
Manage what matters most.

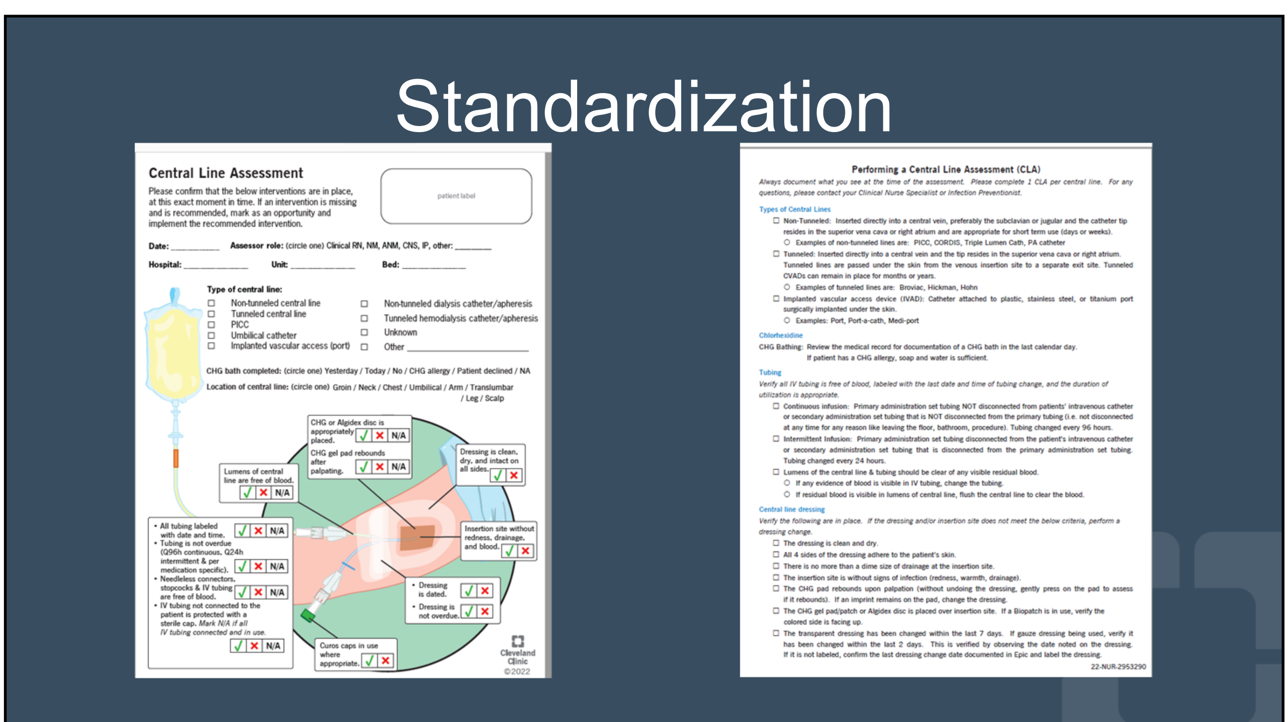
STANDARDIZATION
Sustain what matters most.

PROBLEM SOLVING
Improve what matters most.

STANDARDIZATION
Sustain what matters most.







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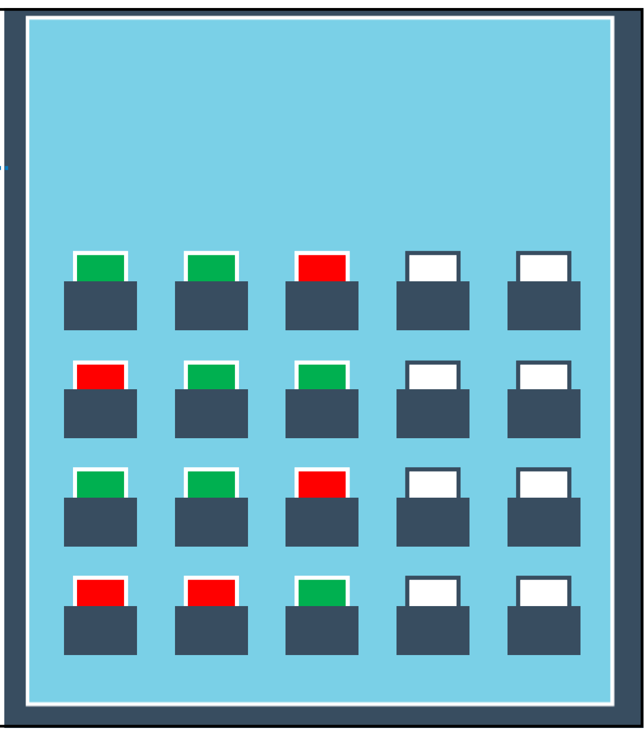
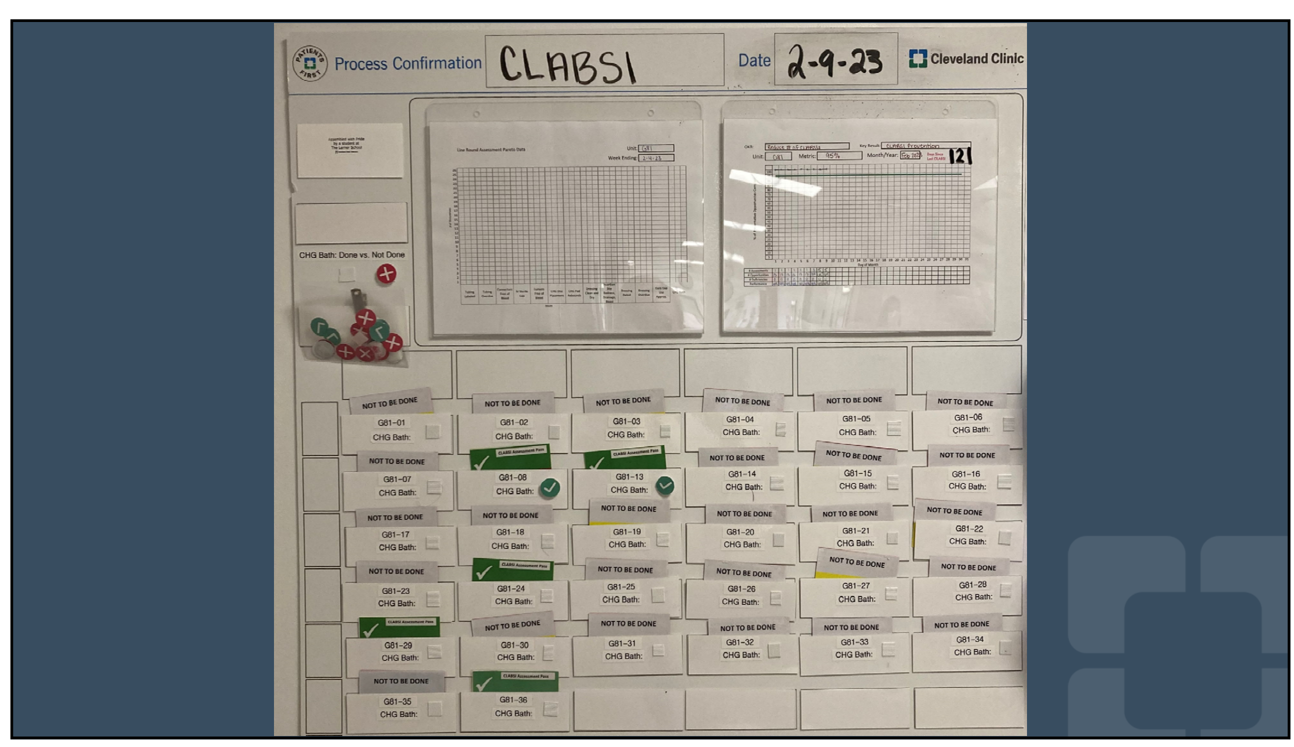
PROCESS CONFIRMATION

Start with a well understood, tested, and documented process.

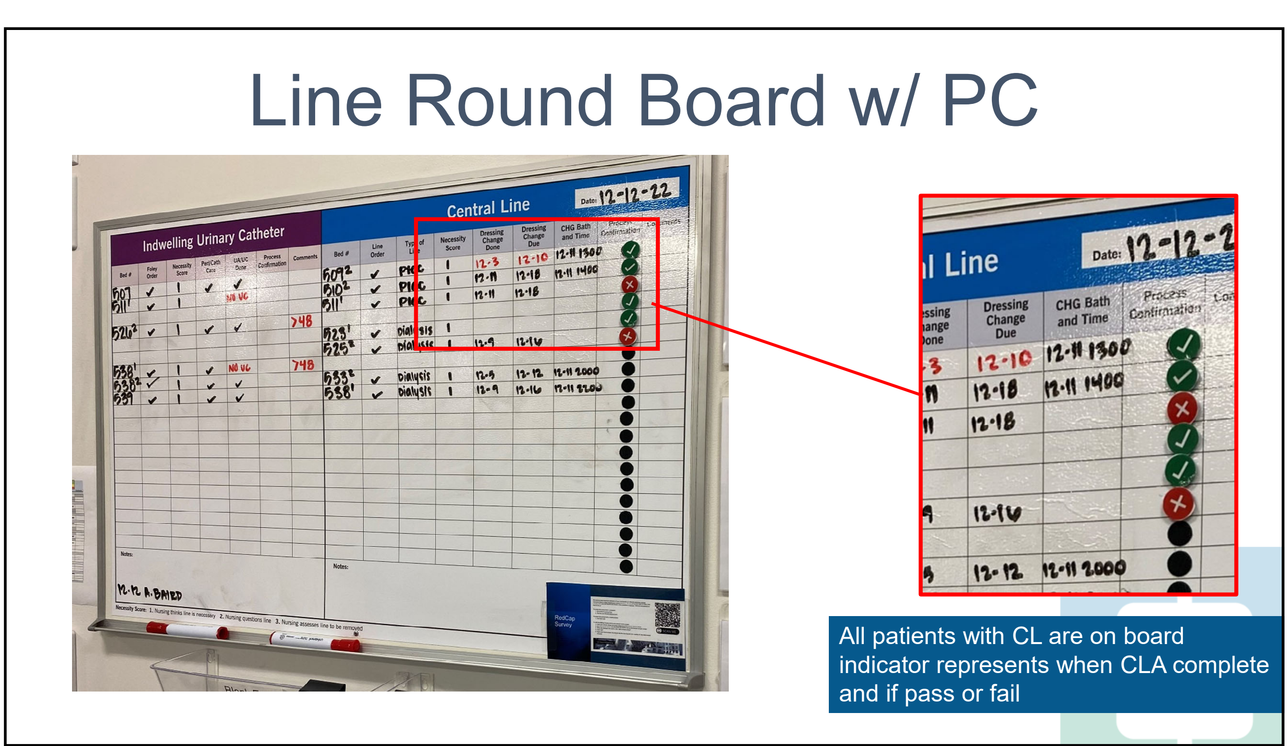
Develop a short assessment that confirms if the process is being sustained.

Use a bold visual tracker to communicate the assessment plan and the results.





Process Confirmation
Date
Process Confirmation
Date


Line Round Board w/ PC
Indwelling Urinary Catheter
Central Line
Date: 12-12-22
Dressing Change Due
CHG Bath and Time
Process Confirmation
All patients with CL are on board indicator represents when CLA complete and if pass or fail

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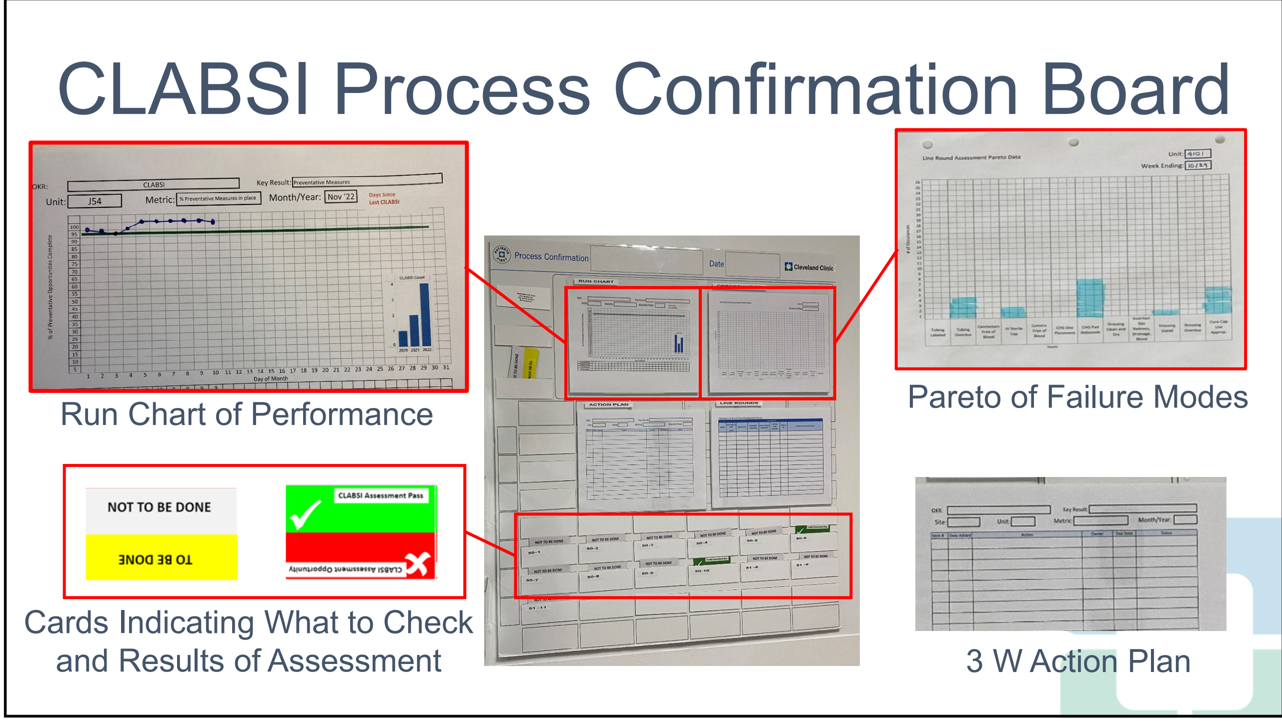
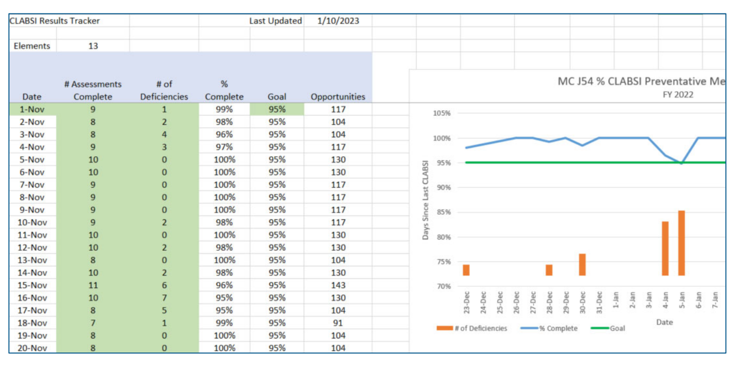


Tracking and Reporting

A standardized spreadsheet was created for each unit to track the following:

- # Assessments Completed
- # of Deficiencies (Failure Modes)
- % of Preventative Measures in Place (Run Chart)
- Failure Mode by Cause (Pareto)
- Blank Forms/Cards
- Card Template
- Standard Work

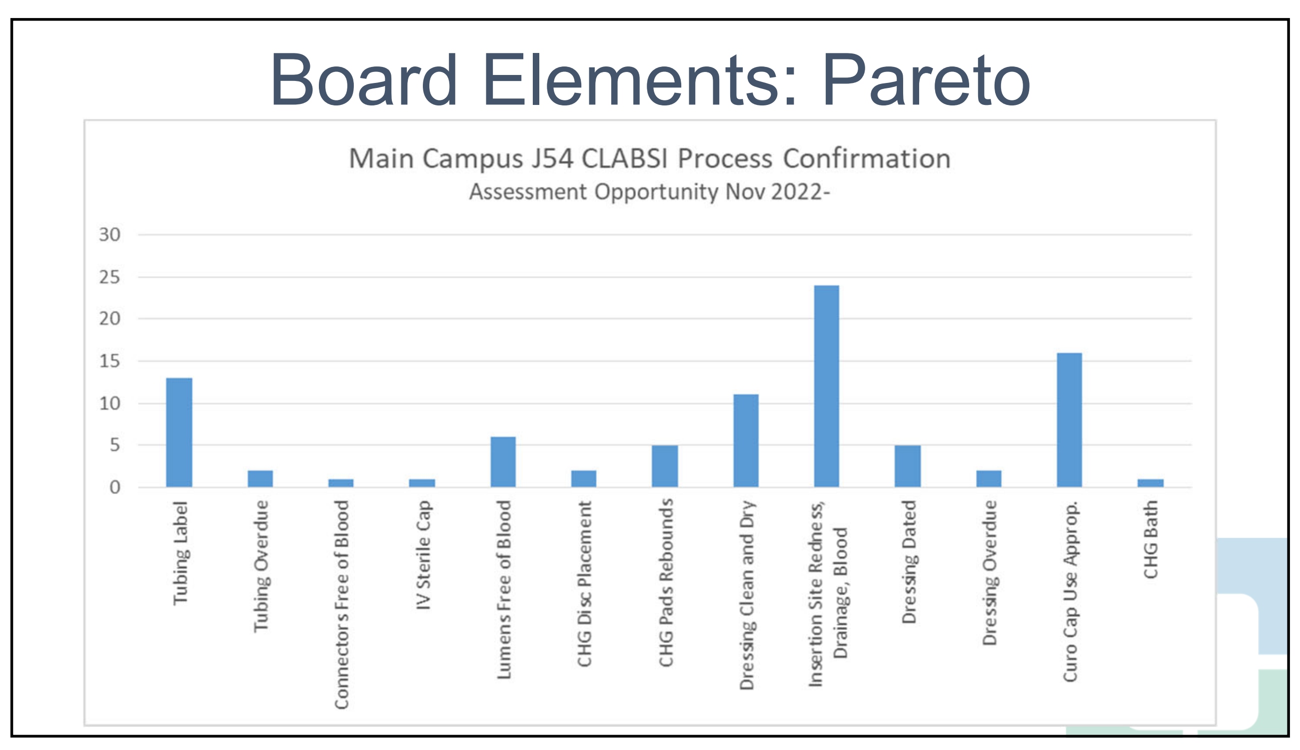


CLABSI Results Tracker — Last Updated 1/10/2023

Elements 13

Date	# Assessments Complete	# of Deficiencies	% Complete	Goal	Opportunities
1-Nov	9	1	99%	95%	117
2-Nov	8	2	98%	95%	104
3-Nov	8	4	96%	95%	104
4-Nov	9	3	97%	95%	117
5-Nov	10	0	100%	95%	130
6-Nov	10	0	100%	95%	130
7-Nov	9	0	100%	95%	117
8-Nov	9	0	100%	95%	117
9-Nov	9	0	100%	95%	117
10-Nov	9	2	98%	95%	117
11-Nov	10	0	100%	95%	130
12-Nov	10	2	98%	95%	130
13-Nov	8	0	100%	95%	104
14-Nov	10	2	98%	95%	130
15-Nov	11	6	96%	95%	143
16-Nov	10	7	95%	95%	130
17-Nov	8	5	95%	95%	104
18-Nov	7	1	99%	95%	91
19-Nov	8	0	100%	95%	104
20-Nov	8	0	100%	95%	104

The tracking tool was designed for minimal data entry. Leaders only need to enter 2 numbers each day and Pareto data monthly.



So how does this all come together?

- What matters most → CLABSI
- How are we performing →
- What's getting in the way →
- Standardization / PC

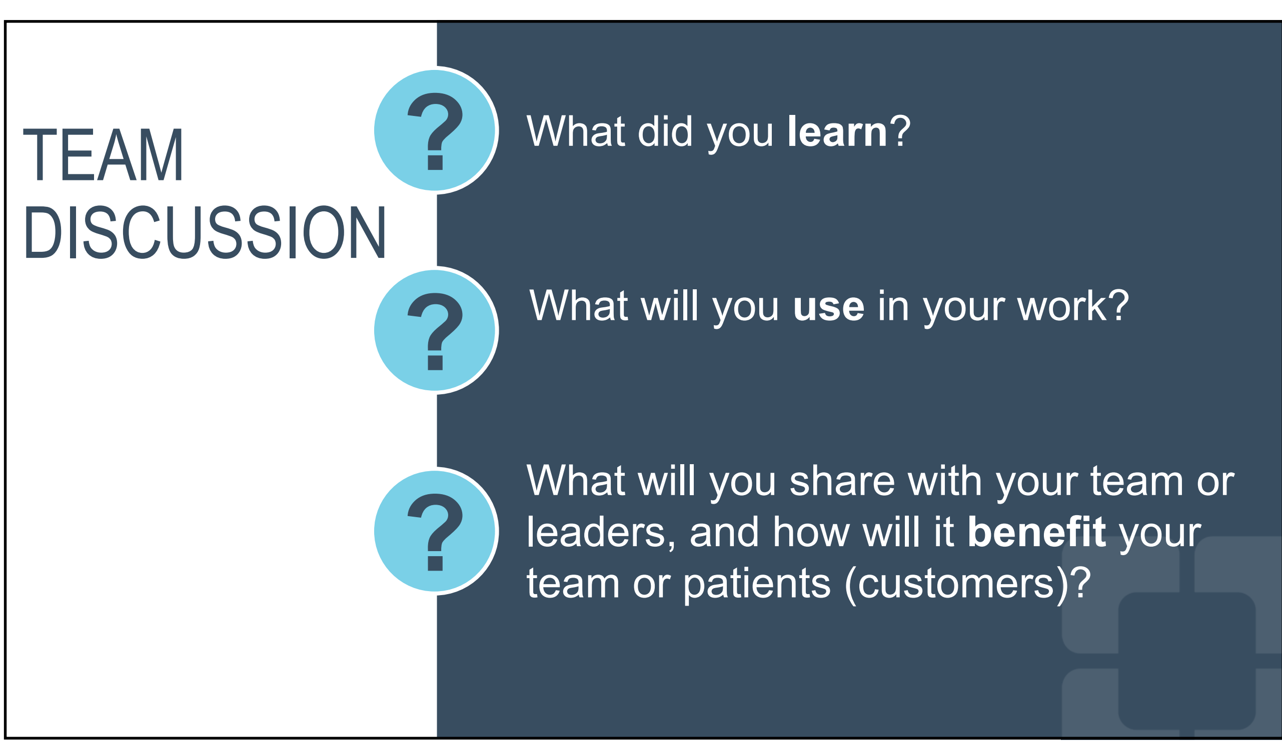
Tier 1- nurses to NM (unit level)	Tier 2 NM to ND (service line)	Tier 3- ND to CNO	Tier 4 - CNO to hospital	Tier 5- hospital to ACNO	Tier 6- ACNO to ET
Days since last CLABSI on unit	Days since on unit	Days since on service line	Days since CLABSI in hospital	Days since CLABSI in hospital	Days since CLABSI in Enterprise
# patients with central lines	# patients w/ central lines	# patients w/ central lines	# patients with central lines		
Room numbers- central lines					
# Assessments previous day	# Assessments previous day	# Assessments previous day			
% CLAs completed	% CLAs completed	units with % CLAs completed <95%			
High Reliability: # CLA perfect from previous day	# CLA perfect from previous day	# CLA perfect from previous day	% CLAs perfect in hospital	% CLAs perfect in hospital	Hospitals with CLA % perfect, less than 95%
details regarding fall outs from previous day (elements of CLA)	details regarding fall outs from previous day	details regarding fall outs from previous day			

So how do we sustain and grow new leaders in this system?

- Onboarding
- Step into existing systems
- Highlight examples of who's doing it well
- Leader rounding
- 1 on 1 Coaching
- CI Model and CI is part of formal nursing leadership development program (nurse manager basics, residency and fellowship), Shared governance council
- SolVE

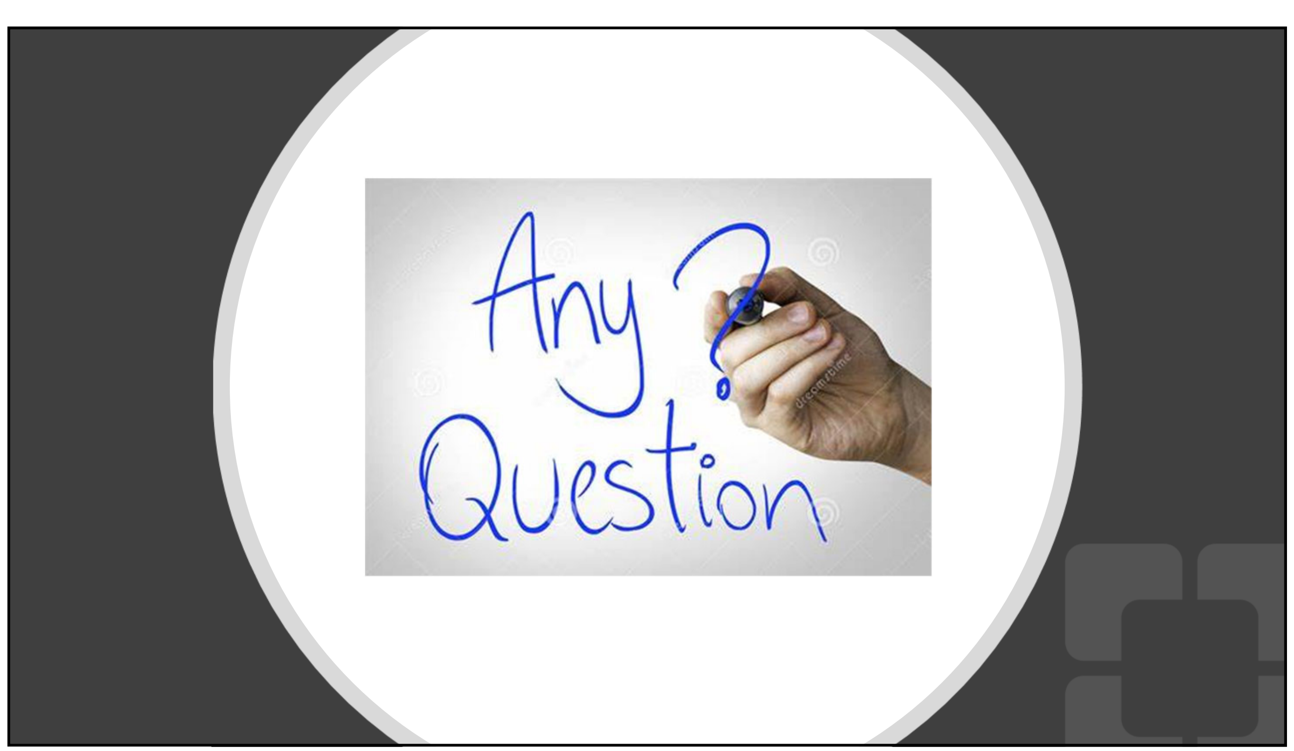
What if leaders don't/won't/can't?

- Start with WHY: team engagement and improved outcomes
  - "It's not just a bath!" "Look at the outcomes"
- Support the caregiver: Identify and address barriers
- Clarity - this is performance expectation and part of annual performance review
- Part of our OKRs



Key Takeaways

- Reflections from a health care executive on improving patient care
  - Easy to determine what matters most
  - More difficult to ensure entire TEAM knows what matters most – and how to improve it!
  - How do you know if you are getting there?



Every life deserves world class care.