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Improvement in Follow-up Communication for Resident-Identified Patient Safety and Hospital Process Issues

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Background

- Lean Concepts:
  - Successfully utilized in health systems to prioritize high-quality care.
  - Daily Management Systems (DMS): key component to empower front line workers to identify gaps.
- Children's Mercy Resident Readiness Huddle:
  - Started 2018, 0700-0710 daily
  - Inpatient Seniors prepare for workday and raise administrative and patient safety concerns.
    - Appropriate Quick Hits (QH) are escalated to hospital leadership.
  - Ideal state: Resolution of QH is cascaded back to residents as front-line providers
- Gap: <10% residents are available at initial QH discussion or present when resolution is announced.

DMS Huddle Board

(example)

Resident Readiness Board

WORKLOAD

- Hospital Census: 325, Red
- Boarding patients: Zero, Green

	Team 1	Team 2	Team 3	Team 4
# Patients	15	14	15	8
# Discharges	2-3	1-2	5-6	1
SAFETY	Red	Green	Green	Green
METHODS	Green	Green	Green	Green
EQUIPMENT	Green	Red	Green	Green
SUPPLIES	Green	Green	Green	Green
STAFFING	Green	Green	Green	Red

SITUATIONAL AWARNESS

-Team 1 is Red for Safety
-Fluid bolus not given upon arrival to the floor
-Team 2 is Red for Equipment
-Team computer broken
-Team 3 is Red for Staffing
-Interns are at academic ½ day

ANNOUNCEMENTS

1. ACGME Survey is due
2. JACHO surveyors are on-site

RECOGNITIONS

-Kudos to Dr. Jones for her Great Catch!

Quick Hits and Projects

SMESS	Date	Owner	Issue	Due Date	Countermeasure	Status
Safety	1/1	Chiefs	Code page did not activate	1/3	Raised to Tier 2	⊕
Methods	1/3	PD's	GI patient admitted to wrong team	1/4	Clarification with GI leadership	⊕

6 ft

4 ft

Objectives

- Aim: Improve the weekly percentage of findings from resolved QH communicated to every resident from 0% to >95% within 6 months.

Methods

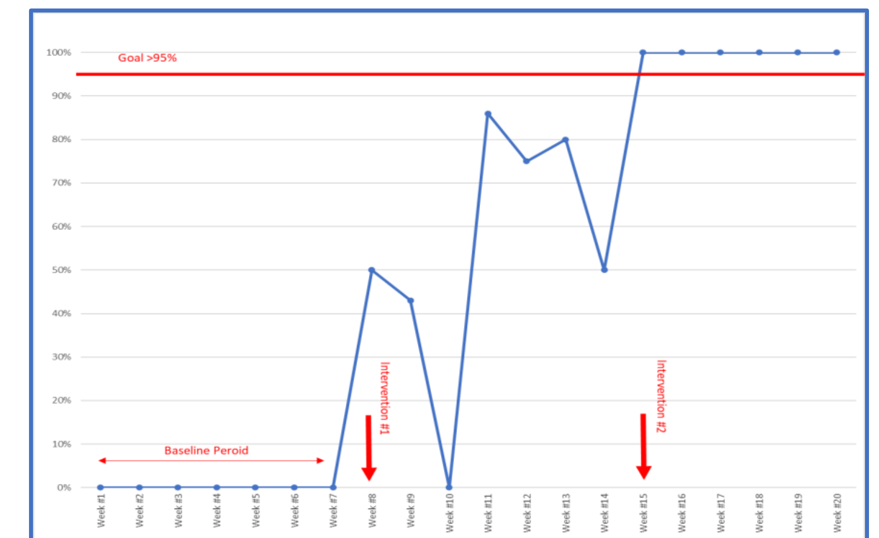
- QH tracked daily and root causes identified
- Outcome measure:
  - % of weekly QH communicated to all residents
- Process Measure:
  - Number of weekly QH identified for escalation
- Plan-Do-Study-Act Cycles:
  - 1) Standardized process for identifying QH requiring report back to all residents
  - 2) Audit and feedback to Residency Program leadership regarding transmission of resolved QH

Results

- 83 QH over 20 weeks (Avg 4.2 per week)
  - Safety-38, Methods-39, Equipment-3
- 45 escalated beyond Residency Program leadership
  - 23-Incident Report
  - 18-Med/Surg Huddle
  - 8-Physician Safety Officer Huddle
  - 1-CEO Huddle

Results

Figure 1: Percent of Quick Hits Shared with All Residents.



Conclusions

- Improvement methodology resulted in sustained communication of resolved QH back to all residents.
- Audit and feedback had the greatest impact.
- Further study needed to determine patient safety impact and resident retention.

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