Clinical Microsystems

A Path to Healthcare Excellence

DRAFT

Assessing, Diagnosing and Treating Your Long Term Care Facility

http://www.jointcommission.org/HTBAC/LTC/

www.clinicalmicrosystem.org

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All forms and examples are available electronically at
http://www.jointcommission.org/HTBAC/LTC/ and www.clinicalmicrosystem.org

Special consideration to the many organizations and colleagues who have made critical substantive contributions to the development of these materials. Especially, Center of the Evaluative Clinical Sciences at Dartmouth Medical School in Hanover, New Hampshire, The Clough Center at New London Hospital in New London, New Hampshire and The Joint Commission in Chicago, Illinois.

WITHIN CLINICAL MICROSYSTEMS

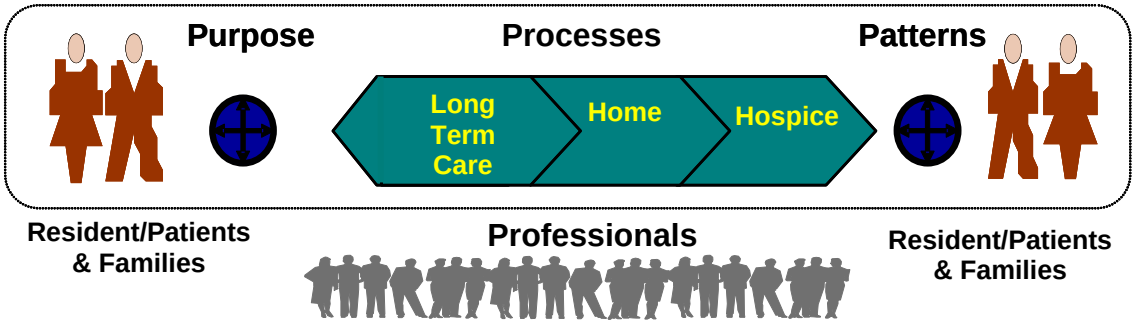
Strategies for improving “The place where residents/patients, families and care teams meet.”

ASSESSING, DIAGNOSING AND TREATING YOUR CARE UNIT

AN OVERVIEW

Many interdisciplinary health professionals come together to provide care and services to long term care residents/patients. We call this place where residents/patients, families, and care teams come together the

Long Term Care Clinical Microsystem



Your clinical microsystem consists of individual contributing units as shown in the diagram. Collectively, these contributing units come together to provide care for your residents/patients. Your clinical microsystem has essential functions that must be carefully assessed and improved to result in the best possible outcomes. Each person’s quality of care depends on what happens within each contributing unit and the handoffs between contributing units. Microsystems also include residents/patients, families, staff, processes, technology and recurring patterns of information, behavior, and results. The microsystem is where

- Care is made
- Quality, safety, reliability, efficiency and innovation are made
- Staff morale and resident/patient* satisfaction are made

**The term “patient” may be used to represent both patient and resident in the long term care setting.*

Clinical microsystems are the front line units that provide day-to-day health care. It is the "sharp" end of health care and can most easily be thought of as the "places where residents/patients, families and care teams meet."

Technically, clinical microsystems can be seen as the smallest replicable units in the health care system and are defined as:

"A **small group** of people who work together on a regular basis to provide care to discrete **subpopulations of patients.** It has clinical and business **aims**, linked **processes**, and a shared information environment, and it produces performance **outcomes**."

Clinical microsystems, (the place where care is delivered such as: hospice care, OT, PT, speech) are the building blocks that form the long term care microsystem. The focus of this workbook is two-fold: 1) "**within**" these units–easily identified based on their physical location, and 2) "**between**" the contributing units of the long term care microsystem. The intent is not to suggest silos of care, but to increase awareness of the individual units and the overall process of long term care including handoffs between contributing units. The whole long term care microsystem reflects a common purpose.

Long Term Care Quality = Quality Microsystem$_1$ + Quality Microsystem$_2$ Quality Microsystem$_{3\text{-}n}$

For quality of care to be improved and to be sustained, work must continually be done within and across the respective microsystems. Therefore, all health care professionals, this is inclusive of everyone working within the microsystem, have two jobs. Job 1 is to provide high quality, safe, patient-centered care. Job 2 is to continually work to improve care.

To effectively accomplish these two jobs, improvement efforts must be blended into the every day activities of everyone. Absent this dedicated effort to continually improve how both work is done and care is provided, optimal quality will not be achieved and the unit, as a microsystem, will not perform at its highest level.

IOM Six Aims

In 2001, the Institute of Medicine (IOM) described a "quality chasm" that exists within today's health care system. The IOM called for fundamental reform of health care to ensure that all Americans receive care that is safe, effective, patient-centered, timely, efficient and equitable. In its report, Crossing the Quality Chasm: A New Health System for the 21st Century, the IOM articulated six quality aims for improving care.

QUALITY AIMS

1. **Safe** – avoiding injuries to patients from care that is intended to help them.

2. **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.

3. **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

4. **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care.

5. **Efficient** – avoiding waste, in particular waste of equipment, supplies, ideas, and energy.

6. **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographical location, and socioeconomic status.

Finding time to improve care can be difficult, but the only way to improve and maintain quality, safety, efficiency and flexibility is by blending analysis, change, measuring and redesigning into the regular patterns and the daily habits of front-line clinicians and staff. Absent the intelligent and dedicated improvement work by all staff in all units, the quality, efficiency and pride in work will not be made nor sustained.

This workbook provides the tools and methods that will help staff and caregivers achieve the goals **within** and **between** the clinical microsystem. The tools in this workbook present an approach to provide effective collaboration of residents/patients, families, caregivers, staff, and senior leaders: in conjunction with an effective use of technology and performance data within the clinical microsystem. These methods can be adapted to a wide variety of specialized clinical settings, large and small, urban and rural, community-based, corporately affiliated and academic.

IMPORTANT REMINDER: These tools are intended to provide an organizing structure that can be adapted to local settings.

A Path Forward

This workbook guides you and those who work with you to a higher level of performance. Just as you can assess, diagnose and treat residents/patients, you can assess, diagnose and treat your clinical microsystem, in this case the long term care facility.

The steps in the workbook help you evaluate how your long term care facility functions and how it can be improved. Additional tools specific to the long term care facility are available. The workbook's tools and forms are based upon the experiences and research of individuals and clinical teams including long term care facilities around the United States and the world. While this is not the only way in which improvement can be achieved, it is a way that has been demonstrated to be effective in achieving higher quality care, enhanced workforce morale, satisfaction and partnerships with people.

To help you in the process, additional coaching is available through the enclosed DVD. A specific segment on the DVD helps explain in more detail how to use the workbook and how to perform the specific steps in assessing, diagnosing and treating your long term care microsystem.

Colleagues around the USA have implemented this methodology. Seek them out to gain support and advice through the Joint Commission long term care website, http://www.jointcommission.org/HTBAC/LTC

Additional information, forms, tools, and examples are available at the Joint Commission long term care website http://www.jointcommission.org/HTBAC/LTC and the Dartmouth Clinical Microsystem Website: www.clinicalmicrosystem.org

For a clinical microsystem to achieve optimal performance, the steps for enabling improvement are ones that are never ending. Once one cycle of improvement is completed, another cycle can begin and then many more cycles follow. Opportunities for improvement are never-ending as resident/patient care and the worklife experience can always be improved.

STEPS IN THE PATH

The following steps walk you through the process of evaluating and improving your long term care facility. After reviewing the steps, you should read the case studies on p. XXXX to get a better sense of how several microsystems were able to improve.

STEP 1: ORGANIZE A "LEAD TEAM"

Successful sustainable change requires the commitment and active engagement of all members of your long term care clinical microsystem with identified senior leader sponsors. To keep your long term care facility improvement on track and focused, a "Lead Team" of representatives of all roles from the long term care microsystem should be formed. The resident/patient travels across several clinical units; therefore, representatives from all contributing units in the long term care microsystem are included in the Lead Team. For example, your long term care facility Lead Team should include residents/patients and family members, physicians, RNs, LPNs, nurse coordinators, nutritionists, respiratory therapists, rehabilitation staff (PT, OT, and speech), social workers, clerical staff, RNs, administrative staff, and support staff from the inpatient adult or pediatric unit, and key contacts from the specialties such as gastroenterology, endocrine, radiology, and psychology. Along with any other professionals who are regularly providing care and service.

Team Tips:

- Use effective meeting skills and timed agendas to ensure productive meetings.
- Hold "huddles" before your shift begins to review recent activities, plan for the day and subsequent days in a proactive manner (see p.00).
- Hold weekly Lead Team meetings to maintain focus, make plans and oversee improvement work.
- Hold monthly "town hall" meetings to engage and inform residents/patients and families as well as all members of the long term care facility.
- Explore creative ways to communicate and stay engaged with all staff on all shifts and all days of the week. Develop strategies to communicate with resident/patient and family advisors serving on the Lead Team. Use email, newsletters, listservs, paper, visual displays, communication boards and conversation.
- Actively engage residents/patients with the Lead Team. See pg.xxx and the Joint Commission website **http://www.jointcommission.org/HTBAC/LTC/** to learn more about engaging residents/patients and families.

STEP 2: ASSESS YOUR LONG TERM CARE FACILITY

- Review the workbook contents and create a timeline for the assessment process using the worksheet on p.7. Designate individuals who will have principal responsibility for each major section. The whole workbook can be completed at the pace that suits your setting. Some microsystems have the capacity and resources to move quickly through the workbook in a short period of time. Many microsystems need to pace themselves through the workbook and complete the worksheets and assessment over a longer timeline. Some microsystems may need to start an important improvement immediately while starting the assessment process. In this case, the ongoing assessment will give you valuable context and will help you make better improvements.
- Complete an assessment of your long term care facility based on Purpose, Patients, Professionals, Process, Patterns (the 5Ps) and Metrics That Matter. The worksheets in this workbook will guide you. The aim is to create the big picture of your long term care facility to see beyond one person at a time. Assessing the "5Ps", using and then reflecting on their connections and interdependence usually reveal new improvement and redesign opportunities.
- Metrics that Matter and Nursing Home Quality Initiatives (http://www.cms.hhs.gov/NursingHomeQualityInits/) to determine current performance and goals to strive for.
- This assessment process is best when completed by the interdisciplinary Lead Team. Building common knowledge and insight into the microsystem by all members of the long term care facility will create a sense of equal value and ability to contribute to improvement activities.

Remember, however you choose to progress through the workbook, it should be done within the context of your interdisciplinary Lead Team.

STEP 3: MAKE A DIAGNOSIS

The Lead Team must analyze the 5Ps assessments and Metrics That Matter worksheets and identify a "theme" for improvement. A theme may be selected using the 7 Worthy Goals and the IOM's Six Aims–safety, effectiveness, patient-centered, timeliness, efficiency and equity. Opportunities for improvement may come from within your own microsystem, your organization strategic goals, or may come from outside your microsystem. Focus on improving only one theme at a time and working with all the "players" in your system to make a big improvement in the area selected.

STEP 4: TREAT YOUR MICROSYSTEM

Based on your selected theme, create a specific aim statement and identify measures that will keep everyone focused and productive. Use proven quality improvement techniques such as PDSA (plan, do, study, act) **pg.xx** and SDSA (standardize, do, study, act) **pg. xx** to test changes and then ensure the improvements are adopted into the workflow.

STEP 5: FOLLOW-UP

Improvement in health care is a continuous journey. Monitor the new patterns of results and move to new themes. Embed new habits into daily work with the use of "huddles" to review and remind staff, weekly Lead Team meetings, monthly "town hall" meetings, data walls and storyboards. These reminders keep everyone focused on improvements and sustaining results.

STEP 1

FORM YOUR LEAD TEAM

Which Senior Leaders will “sponsor” long term care improvement?

	Short-Term Resident/Patient	Long-Term Resident/Patient
Administrator		
Director of Nursing		
Medical Director		

Who will be on the Lead Team for improvement and attend regular meetings?

	Short-Term Resident/Patient	Long-Term Resident/Patient
Administrator		
Director of Nursing		
Social Worker		
CNA/LNA		
Dietician		
MDS Coordinator		
Rehab Staff (PT, OT, Speech)		
Respiratory Therapist		
LPN		
RN		
Patient/Family Advisor 1-2		
Other		

Who are the “as needed” members that will be included?
Identify key contacts for each supporting unit such as gastroenterology, endocrine, dietary, pharmacy, and radiology. These members will be included based on the process being considered.

Attending Physician	Outside org.	Medical Equipment	
Pharmacy	Vendor		

Regular Meeting Time_____ **Date** _____

Location_____

List communication strategies to share information with all staff of the involved in the microsystem and residents/patients & families. For example, newsletters, bulletin boards, emails, and all staff meetings

Long Term Care Facility Assessment of Data Sources and Data Collection

- With your interdisciplinary Lead Team, review this workbook. **Use this form to determine which measures you can obtain from your organization and therefore don't need to use the worksheets.** Be sure the data is current and not months old.
- Determine which worksheets will be used. Plan who, when, and how the worksheets will be completed
- Decide who oversees the compilation of each worksheet or alternative data source
- Create your timeline

Page/Type of Data	Page	Data Source/Data Collection Action	Date/Owner
Know Your Residents/Patients			
Estimated Age Distribution of Residents/Patients			
Resident/Patient Satisfaction			
Top 10 Diagnoses/Conditions			
Top 5 Services Used			
ED Visit Rate			
Through the Eyes of the Resident/Patient			
Point of Entry			
Discharge Disposition			
Resident/Patient Population Census			
Know Your Professionals			
Current Staff			
MD			
On-Call Staff			
Supporting Departments			
Diagnostic Departments			
Personal Skills Assessment			
Activity Survey			
Staff Satisfaction			
Referring Facility			
Know Your Processes			
Pre-admission assessment			
Admission process			
Usual Resident/Patient care			
Change of shift process			
Discharge process			
Transfer to another facility process			
Medication Administration			
Care Plan Process			
Core & Supporting Process Assessment			
Activities Process			
Know Your Patterns			
Unplanned Activity Tracking			
Telephone Tracking Log			
Most Significant Patterns			
Successful Change			
Most Proud of			
Financial Status			
Incident Tracking			

Know Your Outcome/Process Measures			
Does every member of the facility meet regularly as a team?			
How frequently?			
Most significant pattern?			
Are you aware of the Nursing Home Quality Initiatives?			
Review and discuss safety and reliability?			
What have you successfully changed?			
What are you most proud of?			
What is your financial picture?			
Metrics that Matter			
Regulatory Compliance			

STEP 2

ASSESS YOUR CARE CENTER

PURPOSE

Why does your long term care facility exist?

Raise this question to EVERYONE, including residents/patients & families in your long term care facility to create the best statement of purpose that everyone can relate to. Use your purpose to guide decision making and to focus all improvements.

RESIDENTS/PATIENTS

Take a close look at your care center; create a "high level" picture of the RESIDENT/PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the residents/patients view the care they receive? Use the Profile to review "Know Your Residents/Patients."

Determine if there is information you need to collect or if you can obtain this data from existing sources. Remember, the goal is to collect and review data and information about residents/patients and families that might lead to newly designed processes and services.

Long Term Care Facility Profile

Est. Age Distribution of Residents/Patients:	**%**
Pediatric	
20-50 years	
51-65 years	
66-80 years	
>80 years	
% Females	

Living Situation Prior to Admission	
Married	
Domestic Partner	
Live Alone	

List Your Top 10 Diagnoses/Conditions	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Point of Entry	**#/Mo**
Hospital	
Home/Independent Living	
Assisted Living	

Resident Satisfaction Scores	% Excellent
Nurses	
Doctors	
Rehabilitation Staff	
Environment	
Chaplin	
Social Work	
Recreation Therapy	
Pain	
Discharge % Yes	
Overall	

Pt Population Census: Do these numbers change by season? (Y/N)	**#**	**Y/N**
Census by Week		
Census by Month		
Census by Year		

Live with Others	
Skilled Nursing Facility	
Nursing Home	
Homeless	
Assisted Living	
Other	

Admitting Service	**%**
Social Services	
Physicians	
Nursing	

Discharge Disposition	**#/Yr**
Home	
Home with Home Health Care	
Assisted Living	
Hospital	
Emergency Department	
Skilled Nursing Facility	
Rehab Facility	
Death	

Frequency of Inability to Admit Resident		
% Medicare		
% Medicaid		
Re-admitted to Hospital		
% Private Pay		

Resident/Patient Type	**%**	**LOS**	**Range**
Post Acute/Medically Complex			
Physical Rehabilitation PT, OT, Speech			
Dementia			
Palliative/end of life care			
Bariatric			
Pediatric			
Gero-psych			
Other			

Patients

- Residents/patients and families have valuable insight into the quality and process of care we provide. Two surveys are included here: Satisfaction with Access to Care and the Resident/Patient Viewpoint Survey that measures overall satisfaction. You can choose to measure resident/patient feedback specific to "access to care"-how residents/patients and families experience getting an appointment- using the Resident/Patient Access Survey. Real time feedback can pave the way for rapid responses and quick tests of change. This "Point of Service" Survey can be completed at the time of service to give real time measurement of satisfaction.
- You can also choose to measure the overall visit experience using the Resident/Patient Viewpoint Survey (p.XX).
- Conduct the Resident/Patient & Family Satisfaction Surveys for 2 weeks with residents/patients and families if you currently DO NOT have a survey method. If you have a method, be sure the data is up to date and reflects the current state of your long term care facility.

Resident/Patient Satisfaction with Care Experience Survey "Point of Service"

Date _____

Think about this Long Term Care Facility visit.

1. How often did clinical staff listen carefully to you?

❑ **Always** ❑ **Usually** ❑ **Sometimes** ❑ **Never**

2. How often did your attending physician listen carefully to you?

❑ **Always** ❑ **Usually** ❑ **Sometimes** ❑ **Never**

3. How often was the area around your room quiet at night?

❑ **Always** ❑ **Usually** ❑ **Sometimes** ❑ **Never**

4. How was your pain controlled?

❑ **Always** ❑ **Usually** ❑ **Sometimes** ❑ **Never** ❑ **Not Applicable**

5. Did staff talk with you about whether you would need help when you left the nursing facility?

❑ **Yes** ❑ **No** ❑ **Not Applicable**

6. How would you rate your overall nursing facility experience?

❑ **Excellent** ❑ **Very Good** ❑ **Good** ❑ **Fair** ❑ **Poor**

7. Would you recommend this nursing facility to your friends and family?

❑ **Definitely Yes** ❑ **Probably Yes** ❑ **Probably No** ❑ **Definitely No**

8. What would make this nursing facility better for you?

_____

_____

https://www.cahps.ahrq.gov/content/products/NH/PROD_NH_Intro.asp?p=1022&s=223

Skilled Nursing Family Satisfaction Survey Date___

Here are some questions about this long term care facility. We would like to know how you would rate each of the following.

Overall Satisfaction	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
1. How would you rate your overall satisfaction with this facility?	❑	❑	❑	❑	❑
2. What is your recommendation of this facility to others?	❑	❑	❑	❑	❑
Quality of Life					
3. Meeting the resident's/patient's choice and preferences	❑	❑	❑	❑	❑
4. The respect show to the resident/patient by staff	❑	❑	❑	❑	❑
5. Meeting the resident's/patient's need for privacy	❑	❑	❑	❑	❑
6. Offering the resident/patient opportunities for friendships with other residents/patients	❑	❑	❑	❑	❑
7. Offering the resident/patient opportunities for friendships with staff	❑	❑	❑	❑	❑
8. Offering the resident/patient meaningful activities	❑	❑	❑	❑	❑
9. Meeting the resident's/patient's religious and spiritual needs	❑	❑	❑	❑	❑
10. How safe it is for the resident/patient	❑	❑	❑	❑	❑
11. The security of the resident's/patient's personal belongings	❑	❑	❑	❑	❑
12. How enjoyable the dining experience is for the resident/patient	❑	❑	❑	❑	❑

Quality of Care

Here are some general questions about the resident's/patient's satisfaction with the long term care facility.

13. The quality of care provided by the nurses (RNs/LNAs/LPNs) ❑ ❑ ❑ ❑ ❑

14.The quality of care provided by the nursing assistants

❑ Agree ❑ Disagree ❑ Not sure

15. In the last 12 months, how many times have you or the patient gone to the emergency room for care?

❑ None ❑ One time ❑ Two times ❑ Three or more times

16. In the last 12 months, was it always easy to get a referral to a specialist when one was needed?

❑ Yes ❑ No ❑ Does not apply to me

17. In the last 12 months, how often did you or the patient have to see someone else when you wanted to see a personal doctor or nurse?

❑ Never ❑ Sometimes ❑ Frequently

18. Are you or the patient able to get to appointments when you choose?

❑ Never ❑ Sometimes ❑ Always

19. Is there anything our Long term care facility can do to improve the care and services?

❑ No, everything is **satisfactory**

❑ Yes, **some things** can be improved: (please specify) _____

❑ Yes, **lots of things** can be improved: (please specify) _____

20. Did you or the patient have any good or bad surprises while receiving care?

❑ Good ❑ Bad ❑ No Surprises

Please describe: _____

_____

About You or the Patient

20. In general, how would you rate your overall health or the health of the patient?

❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

21. What is your age or the age of the patient?

❑ Under 18 years ❑ 18 – 25 years ❑ 26 – 35 years ❑ over 35 years

22. What is your gender or the gender of the patient? ❑ Male ❑ Female

See the Hospital CAHPS survey (www.cms.hhs.gov) for other questions that ask the resident's/patient's perspective on care.

- Gain insight into how your residents/patients & families experience care in your long term care facility. One simple way to understand the resident/patient & family experience is to experience the care. Members of your staff can assume the role of a person in your long term care facility. Try to make this experience as real as possible, this form can be used to document the experience.
- You can also capture the person's experience through direct observation of care, taking pictures, or making an audio or videotape.
- This exercise can be adapted to any setting, including the long term care facility.

Through the Eyes of Your Residents/Patients & Families

Tips for making the experience most productive

1. Determine with your staff where the starting point and ending points should be, taking into consideration the usual journey of residents/patients across several contributing units.
2. Two members of the staff should role play with each playing a role: resident/patient and partner/family member.
3. Set aside a reasonable amount of time to experience the patient journey. Consider doing multiple experiences along the patient journey at different times to piece together the whole journey. Remember care occurs 24/7/365. Observe on different shifts and days.
4. Make it real. Include time with registration, lab tests, new resident/patient appointment, follow-up, minor procedures, prescriptions, and referrals. Sit where the resident/patient sits. Wear what the resident/patient wears. Experience the diagnostic and treatment process. Make a realistic paper trail including chart and lab reports.
5. During the experience note both positive and negative experiences, as well as any surprises. What was frustrating? What was gratifying? What was confusing? Was there variation between shifts? Again, an audio or video tape can be helpful.
6. Debrief your staff on what you did and what you learned.

Date _____ Staff Members _____

Process Begins When _____ Ends When _____

Positives	Negatives	Surprises	Frustrating/Confusing	Gratifying

PROFESSIONALS

KNOW YOUR PROFESSIONALS

Use the following template to create a comprehensive summary picture of your long term care facility. Who does what and when? Is the right person doing the right activity? List all roles, total FTEs and over-time by role. Are the roles being optimized? Are all roles that contribute to the resident/patient experience listed? What days and hours is the long term care facility open?

Current Staff	**FTE**			**Long term care facility Days and Times**											
Enter names below totals		Su AM	Su PM	Mo AM	Mo PM	Tu AM	Tu PM	We AM	We PM	Th AM	Th PM	Fr AM	Fr PM	Sa AM	Sa PM
MDs Total															
RNs Total															
ARNPs Total															
LPNs Total															
LNAs/CNAs Total															
Rehab. Specialist Total															
Occupational Therapist															
Physical Therapist															
Therapeutic Specialist															
Speech Therapist															
Respiratory Therapist															
Dietary Total															
Social Worker															
Activities Coordinator															
Secretaries Total															
Administrator															
Others:															

Do you use On-Call Staff? ❑ **YES** ❑ **NO**

Do you use a Float Pool? ❑ **YES** ❑ **NO**

Do you use agency staff? ❑ **YES** ❑ **NO**

Supporting Microsystems

such as dietary, rehabilitation, pharmacy , social work, administration, activity social services

_____ _____

_____ _____

Staff Satisfaction Scores

How stressful is this facility? (% Very Stressful) _____

Would you recommend it as a great place to work? (% Strongly Agree) _____

- Creating a joyful work environment starts with a basic understanding of staff perceptions of the facility. All staff members should complete this survey.
- Ask all long term care facility staff to complete the Staff Survey. Often you can distribute this survey to any professional who spends time in your facility. Set a deadline of one week and designate a place for the survey to be dropped off. You may have an organization-wide survey in place that you can use to replace this survey, but be sure it is CURRENT data, not months old, and that you are able to capture the data from all professionals specific to the workplace.

Staff Satisfaction Survey

1. I am treated with **respect** every day by everyone that works in this long term care facility.

❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

2. I am given **everything I need**—tools, equipment, and encouragement—to make my work meaningful to my life.

❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

3. When I do good work, someone in this long term care facility **notices** that I did it.

❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

4. How **stressful** would you say it is to work in this long term care facility?

❑ Very stressful ❑ Somewhat Stressful ❑ A Little Stressful ❑ Not Stressful

5. How easy is it to **ask anyone a question** about the way we care for residents/patients and their families?

❑ Very Easy ❑ Easy ❑ Difficult ❑ Very Difficult

6. How would you rate other people's **morale** and their attitudes about working here?

❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

7. This long term care facility is a **better place** to work than it was 12 months ago.

❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

8. I would **recommend** this long term care facility as a great place to work.

❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

9. What would make this long term care facility **better for residents/patients and their families**?

_____

10. What would make this long term care facility **better for those who work here**?

_____

_____

- Development of each member in the clinic is a key to success for staff and the microsystem. The Personal Skills Assessment tool helps determine the education and training needs of staff. All staff members complete this survey and then discuss an action plan to talk with leadership and other staff. A plan is developed to help members achieve goals so they can become the best they can be.
- This tool provides guidance for individual development plans along with assessing the "group" needs to plan larger learning and training sessions.

Long Term Care Facility–Personal Skills Assessment

Name _____ Facility _____

Role _____ Date _____

Clinical Competencies:

Please create your list of clinical competencies and evaluate.	Want to Learn	Never Use	Occasionally	Frequently
	❑	❑	❑	❑

Clinical Information Systems (CIS):

What features and functions do you use?	Want to Learn	Never Use	Occasionally	Frequently
Provider/On Call Schedule	❑	❑	❑	❑
Patient Demographics	❑	❑	❑	❑
Lab Results	❑	❑	❑	❑
Pathology	❑	❑	❑	❑
Resident/Patient & Family Goals & Action Plan	❑	❑	❑	❑
Review Reports/Notes	❑	❑	❑	❑
Documentation	❑	❑	❑	❑
Direct Entry	❑	❑	❑	❑
Note Templates	❑	❑	❑	❑
Medication Lists	❑	❑	❑	❑
Insurance Status	❑	❑	❑	❑
Durable Power of Attorney	❑	❑	❑	❑
Radiology	❑	❑	❑	❑
MDS/RAI	❑	❑	❑	❑

NOTE: CIS refers to hospital or clinic-based information systems used for such functions as checking in residents/patients, electronic medical records, accessing lab and x-ray information. Customize your list of CIS features to determine skills needed by various staff members to optimize their roles.

Technical Skills:

Please rate the following on how often you use them.	Want to Learn	Never Use	Occasionally	Frequently
CIS	❑	❑	❑	❑
E-mail	❑	❑	❑	❑
PDA (e.g. Palm Pilot)	❑	❑	❑	❑
Digital Dictation Link	❑	❑	❑	❑
Word Processing (e.g. Word)	❑	❑	❑	❑
Spreadsheet (e.g. Excel)	❑	❑	❑	❑

Presentation (e.g. Power Point)	❑	❑	❑	❑

Name _____ Clinic _____

Technical Skills cont'd:				
Please rate the following on how often you use them.	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
Database (e.g. Access or File Maker Pro)	❑	❑	❑	❑
Patient Database/Statistics	❑	❑	❑	❑
Internet/Intranet	❑	❑	❑	❑
Printer Access	❑	❑	❑	❑
Fax	❑	❑	❑	❑
Copier	❑	❑	❑	❑
Telephone System	❑	❑	❑	❑
Voice Mail	❑	❑	❑	❑
Pagers	❑	❑	❑	❑
Tube System	❑	❑	❑	❑
Acudose/Pyxis	❑	❑	❑	❑

Meeting & Interpersonal Skills:	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
What skills do you currently use?	❑	❑	❑	❑
Effective Meeting Skills (brainstorm/multi-vote)	❑	❑	❑	❑
Timed Agendas	❑	❑	❑	❑
Role Assignments During Meetings	❑	❑	❑	❑
Delegation	❑	❑	❑	❑
Problem Solving	❑	❑	❑	❑
Resident/Patient & Family Centered Care	❑	❑	❑	❑
Open and Effective Communication	❑	❑	❑	❑
Feedback – Provide and Receive	❑	❑	❑	❑
Managing Conflict/Negotiation	❑	❑	❑	❑
Emotional/Spiritual Support	❑	❑	❑	❑

Improvement Skills and Knowledge:	**Want to Learn**	**Never Use**	**Occasionally**	**Frequently**
What improvement tools do you currently use?				
Flowcharts/Process Mapping	❑	❑	❑	❑
Trend Charts	❑	❑	❑	❑
Control Charts	❑	❑	❑	❑
Plan/Do/Study/Act (PDSA) Improvement Model	❑	❑	❑	❑
Standardize/Do/Study/Act (SDSA) Improvement Model	❑	❑	❑	❑
Aim Statements	❑	❑	❑	❑
Fishbones	❑	❑	❑	❑
Measurement and Monitoring	❑	❑	❑	❑
Surveys-Patient and Staff	❑	❑	❑	❑
STAR Relationship Mapping	❑	❑	❑	❑

- What do you spend YOUR time doing? What is your best estimation of how much time you spend doing it? The goal is to have the right person doing the right thing at the right time. The group can discuss which activities are or are not appropriate for the individual's level of education, training, and licensure.
- You can start with one group of professionals such as LNAs, dietary staff, RNs, or rehabilitation staff assessing their activities using the Activity Survey. This estimate of who does what is intended to reveal, at a high level, where there might be mismatches between education, training, licensure and actual activities. It is good to eventually have all roles and functions complete this survey for review and consideration. Be sure to create the same categories for each functional role. Some groups may hesitate to make time estimates; if this happens, just ask them to list their activities for the first review.
- Electronic versions, blank sheets and examples can be found at **http://www.jointcommission.org/HTBAC/LTC/**

Activity Survey Sheet

Position: RN	% of Time
Activity: See Patients in Facility Specific Items Involved: • Review chart history • Assess/diagnose patient • Determine treatment plan	30%
Activity:	%
Activity:	%
Activity:	%
Activity:	%
Activity: Dictate/Document Patient Encounter Specific Items Involved: • Dictate encounter • Review transcriptions and sign off	20%
Activity: Complete Forms Specific Items Involved: • Referrals • Workers comp	5%
Activity: Follow-up Phone Calls/Emails Specific Items Involved •	5%
Activity: Manage Charts	5%
Activity: Evaluate Test Results Specific Items Involved: • Review results and determine next actions	5%
Activity: See Patients in Nursing Home	2%
Activity: Miscellaneous Specific Items Involved: • CEU; attend seminars; attend meetings	2%
Total	100%

Position: LNA/CNA	% of Time
Activity: Triage Patient Issues/Concerns • Phone • Face to face •	15%
Activity: Patient/Family Education Specific Items Involved: •	3%
Activity: Direct Patient Care • See patients in clinic • Assist Provider with patients • Injections	30%
Activity: Follow-up Phone Calls/Emails Specific Items Involved: •	22%
Activity: Review and Notify Patients of Lab Results Specific Items Involved: • Normal with follow-up • Drug adjustments	5%
Activity: Complete Forms Specific Items Involved: • Referrals • Workers comp	18%
Activity: Call in Prescriptions Specific Items Involved: •	5%
Activity: Miscellaneous Specific Items Involved: • CME; attend seminars; attend meetings	2%
Total	100%

ACTIVITY OCCURRENCE EXAMPLE

What's the next step? Insert the activities from the Activity Survey here.

Activities are combined by role from the data collected above. This creates a master list of activities by role. Fill-in THE NUMBER OF TIMES PER SESSION (AM and PM) THAT YOU PERFORM THE ACTIVITY. Make a mark by the activity each time it happens, per session. Use one sheet for each day of the week. Once the frequency of activities is collected, the clinic should review the volumes and variations by session, day of week, and month of year. This evaluation increases knowledge of predictable variation and supports improved matching of resources based on demand.

Role: RN	Date:	Day of Week:	
Visit Activities	AM	PM	Total
Triage Patient Concerns	𝍸 ||	𝍸 ||	14
Family/Patient Education	𝍸 |||	|||	11
Direct Patient Care	𝍸 𝍸 𝍸 𝍸 |	𝍸 𝍸 𝍸 𝍸 |	42
Non-Visit Activities			
Follow-up Phone Calls/Emails	𝍸 𝍸	𝍸 𝍸 𝍸 |	26
Complete Forms	𝍸 𝍸 |	𝍸 |||	19
Call in Prescriptions	𝍸 |	𝍸 𝍸	16
Miscellaneous			15

Total	63	65	128

PROCESS

KNOW YOUR PROCESSES

How do things get done in the care center? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays?

Do you use any of the following?

Check all that apply

- ☐ Critical Pathways
- ☐ Rapid Response Team
- ☐ Advanced Directives
- ☐ Durable Power of Attorney
- ☐ Hospice
- ☐ Preceptor/Charge Role
- ☐ Discharge Goals
- ☐ Interdisciplinary rounds

	Create flowcharts of routine processes		#		Identify Supporting Microsystems
1.	Pre-admission assessment			1.	Dietary
2.	Admission			2.	Rehabilitation
3.	Usual resident care			3.	Pharmacy
4.	Change of shift			4.	Social Work
5.	Discharge			5.	Administration
6.	Transfer to another facility			6.	Activity social services
7.	Medication administration			7.	
8.	Care Plan			8.	
9.	Reassessment			9.	

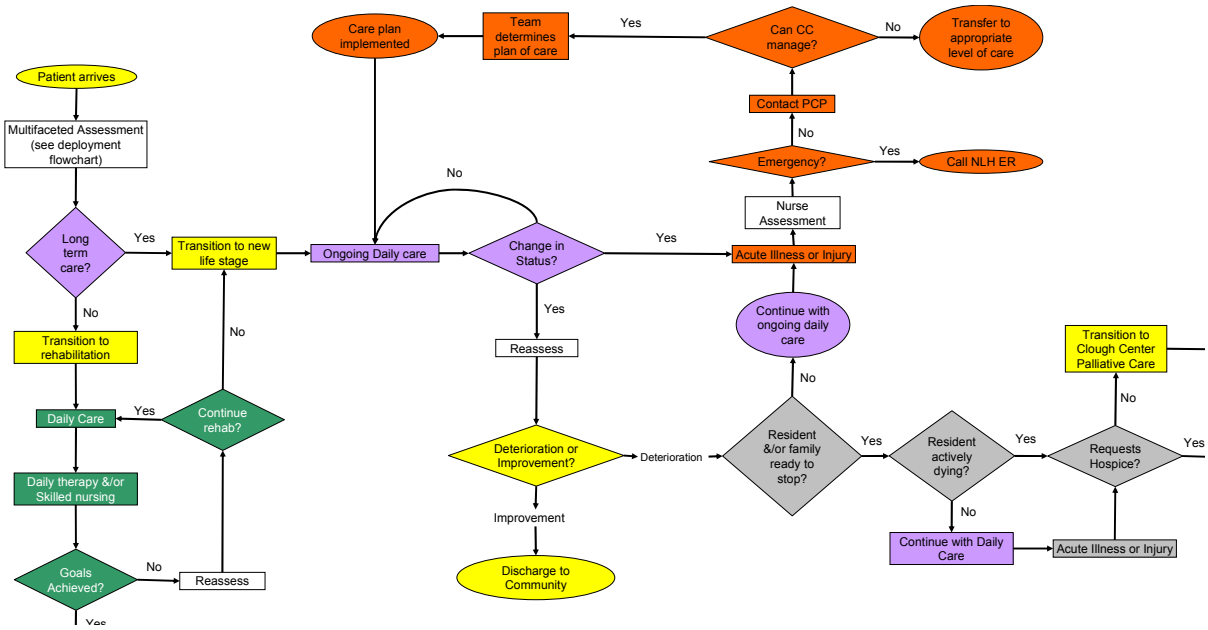
Number of Rooms		Number of Beds		# Turnovers/Bed/Year	

Create flowcharts of routine processes.

- Deming has said, “If you can’t draw a picture of your process you can’t improve anything.” He is referring to the improvement tool of process mapping. With your interdisciplinary Lead Team, create a high level flow chart of the appointment process or the entire treatment experience. Start with just ONE flow chart. Eventually you will wish to create flowcharts for many different processes in your care center and processes with other microsystems. Keep the symbols simple!
- Review the flowchart to identify unnecessary rework, delays and opportunities to streamline and improve.
- See the **http://www.jointcommission.org/HTBAC/LTC/** for LTC specific flowcharts.

1. Overall appointment process
2. Overall treatment process
3.

Core Processes



Symbol Key:

Unclear	Process beginning or end	Decision points	Process flow direction
	Activity step	Waits and delays	Connector (e.g. off page)

Cycle Time Tool

Beginning to have all staff understand the processes and flow of care and services in the care center is a key to developing a common understanding and focus for improvement. Start with the high level process of a patient being admitted to your care center by using the Resident/Patient Cycle Time Tool. You can assign someone to track all admissions for a week to get a sample, or the cycle time tool can be initiated for all admissions in a one week period with many people contributing to the collection and completion of this worksheet.

Typically, other processes will be uncovered to measure and you can create time tracking worksheets like this template to measure other cycle times.

Instructions: Please fill in the time at the time of admission.

Time_____ **Date**_____

Time	
	1. Notification of new resident.
	2. Arrival time to facility.
	3. Resident taken to room.
	4. Resident oriented by staff to room/facility.
	5. Licensed nurse initiates admission process
	6. Orders reviewed.
	7. Date attending physician came to visit resident.
	8. Treatments started (eg. IV)
	9. Medications dispensed.
	10. Tests drawn.
	11. Resident admission complete.

COMMENTS: _____

- Review, adapt and distribute the Core and Supporting Processes evaluation form to ALL staff. Be sure the list is accurate for your facility and then ask staff to evaluate the CURRENT state of these processes. Rate each process by putting a tally mark under the heading which most closely matches your understanding of the process. Also mark if the process is a source of resident/patient complaints. Tally the results to give the Lead Team an idea as to where to begin to focus improvement from the staff perspective.

- Some microsystems create and hang a wall size version of the Core and Supporting Process Assessment chart and ask all staff to select choices. This creates a visual display showing all the ratings and priorities for all staff to see.

- **Steps for Improvement:** Explore improvements for each process based on the outcomes of this assessment tool. Each of the processes below should be flowcharted in its' current state. Based on the flowcharts of the current state of your processes and determinations of your Change Ideas (see p. xx), you will use the PDSA Cycle Worksheet (p.xxx) to run tests of change and to measure your Change Ideas.

Long Term Care Facility Core and Supporting Processes Assessment

Processes	Works Well	Small Problem	Real Problem	Totally Broken	Cannot Rate	We're Working On It	Source of Resident/ Pt/Family Complaint
Admission							
Routine Care							
Transfer from Hospital							
Discharge							
Medication Administration							
Prescription renewals							
At risk for falls							
Adverse Drug Event							
Billing/Coding							
Medical Emergency/ CPR							
Orientation of residents to your facility							
Feeding Residents/Patients							
Goal setting & plan for residents/patients/families							
Prevention assessment/activities							
Chronic disease management							
Hydration and nutrition							

Pulmonary maintenance							
Pulmonary exacerbations							
Infection Control							

PATTERNS

KNOW YOUR PATTERNS

What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss resident/patient care? Are residents/patients and families involved? What are your results and outcomes?

- Does every member of the facility meet regularly as a team?
- How often does your microsystem meet to discuss long term care?
- How do leaders across your microsystem relate to one another?
- Do the members of the facility regularly review and discuss safety and reliability issues?
- Are residents/patients and families involved? (Use http://www.jointcommission.org/HTBAC/LTC/)
- What is the most significant pattern of variation?
- What have you successfully changed?
- What are you most proud of?
- What is your financial picture?
- What are your long term care results and outcomes?
- How do leaders relate to staff?

- Patterns are present in our daily work and we may or may not be aware of them. Patterns can offer hints and clues to our work that inform us of possible improvement ideas. The Unplanned Activity Tracking Card is a tool you can ask staff to carry to track patterns of interruptions, waits and delays in the process of providing smooth and uninterrupted patient care. Start with any group in the staff. Give each staff member a card to carry during a shift, to mark each time an interruption occurs when direct resident/patient care is delayed or interrupted. The tracking cards should then be tallied by each person and within each group to review possible process and system redesign opportunities. Noticing patterns of unplanned activities can alert staff to possible improvements.

- This collection tool can be adapted for any role in the long term care facility to discover interruptions in work flow. Circles in the example indicate processes to further evaluate for possible improvements.

Unplanned Activity Tracking Card

Unplanned Activity Tracking

Name _____

Date _____ Time _____

Place a tally mark for each occurrence of an unplanned activity	Total
Interruptions	
• Phone	
• Secretary	
• RN	
• LPN • Provider	
Admissions	
Phone Calls	
Pages	
Missing Equipment	

EXAMPLE

Unplanned Activity Tracking

Name _____

Date _____ Time _____

Place a tally mark for each occurrence of an unplanned activity	Total
Interruptions	
• Phone 𝍸 𝍸 𝍸	15
• Secretary	
• RN 𝍸 𝍸	(10)
• LPN	
• Provider	
Admissions 𝍸 𝍸 II	(12)
Phone Calls	
Pages 𝍸 𝍸 𝍸 𝍸	20
Missing Equipment	

Missing Supplies	
Missing Chart:	
Missing Test Results	
Emergent Cases	

Missing Supplies 𝍸	5
Missing Chart: 𝍸 𝍸	⑩
Missing Test Results	
Emergent Cases	

- Patterns can be found through tracking the volumes and types of telephone calls. Review the categories on the telephone tracking list to ensure they reflect the general categories of calls your clinic receives. Ask clerical staff to track the telephone calls over the course of a week to find the patterns of each type of call and the volume peaks and valleys.
- Put a tally mark each time one of the phone calls is for one of the listed categories. Total the calls for each day and then total the calls in each category for the week. Note the changes in volume by the day of the week and am/pm.

Facility Telephone Tracking Log

Week of _____	Day of Week		Day of Week		Week Total
	AM	PM	AM	PM	
Family					
Total					
Admitting					
Total					
MD Office					
Total					
Other Hospital					
Total					
Vendors					
Total					
Ancillary Departs.					
Total					
Clinical Resource Coord.					
Total					
VNA/SNF/Other					
Total					
Personal					
Total					
Misdirect Call					
Total					
Phone Advice					
Total					
DAY TOTAL					

METRICS THAT MATTER

- Measures are essential for microsystems to make and sustain improvements and to attain high performance. Review your long term care data to identify gaps in current care. All clinical microsystems are awash with data but relatively few have rich information environments that feature daily, weekly and monthly use of Metrics That Matter (MTM). The key to doing this is to get started in a practical, doable way; and to build out your Metrics That Matter and their vital use over time.
- Some guidelines for your consideration are listed below. Remember these are just guidelines and your microsystem should do what makes sense in the way of collecting, displaying and using measures or Metrics That Matter.

Long Term Care Metrics That Matter

1. **W**hat? Every microsystem has vital performance characteristics, things that must happen for successful operations. Metrics That Matter (MTMs) should reflect your microsystem's vital performance characteristics.

2. **W**hy? The reason to identify, measure and track MTMs is to ensure that you are not "flying blind." Safe, high quality and efficient performance will give you specific, balanced and timely metrics that show:
   a. When improvements are needed
   b. If improvements are successful
   c. If improvements are sustained over time, and
   d. The amount of variation in results over time

3. **H**ow? Here are steps you can make to take advantage of MTMs.

LEAD TEAM

Work with your **Lead Team** to establish the **need** for metrics and their **routine** use. Quality begins with the intention to achieve measured excellence.

BALANCED METRICS

Build a **balanced** set of **metrics** to provide insight into what's working and what's not working. Some categories to consider are: process flow, clinical, safety, patient and family perceptions, staff perceptions, operations, and finance/costs. Avoid starting with too many measures.

Every metric should have an operational definition, data owner, target value and action plan.

DATA OWNER

Start small and identify a data wall owner(s) who is guided by the Lead Team.
Identify a **data owner(s)** for each metric. The owner will be responsible for getting this measure and reporting it to the Lead Team.
Seek sources of data from organization wide systems.
If the needed data is not available, use manual methods to measure. Strive to build data collection in the flow of daily work.

DATA WALL DISPLAYS

A data wall is a designated space to display your Metrics That Matter overtime. Build a data wall and use it daily, weekly, monthly, and annually.
Gather data for each metric and **display** it on the "data wall" reporting

- Current Value
- Target Value
- Action Plan to improve or sustain level

Display metrics as soon as possible–daily, weekly, monthly metrics are most useful–using visual displays such as time trend charts and bar charts.

REVIEW AND USE

Review your set of metrics on a regular basis—daily, weekly, monthly, quarterly, annually.
Use metrics to make needed improvements whenever possible.
Make metrics fun, useful and a lively part of your microsystem development process. Discuss Metrics That Matter frequently and take action on them as needed.

Strongly consider using the metrics reported in the xxxxxxxxspecific registry reports, JCAHO* metrics whenever they are relevant to your microsystem, vital metrics based on your own experience and strategic initiatives, and other "gold standard" sets such as measures from NQF*.

* JCAHO, Joint Commission on Accreditation of Healthcare Organizations; NQF, National Quality Foundation;

- Review the currently determined "best metrics" long term care facilities should be monitoring
- List current performance on these metrics and what targets are.

LONG TERM CARE FACILITY METRICS THAT MATTER

Name of Measure	Goal	Current & Target Values	Definition & Data Owner	Action Plan & Process Owner
Patient-Centered Outcome Measures				
Need for help with Daily Activities				
High-Risk Pressure Sores				
Low-Risk Pressure Sores				
Physically Restrained				
Depression or Anxiety				
Loss of Control of Their Bowels or Bladder				
Catheter Inserted and Left in Bladder				
Most of Their Time in Bed or in a Chair				
Ability to Move About in and Around Room				
Urinary Tract Infections				
Weight Loss				
Flow				
Diversions from department				
Delayed admission/discharge				
ALOS				
Staffing Patterns				
Nursing care hours per patient per day				
Voluntary turnover				
Safety				
Falls per 1000 patient days				
Workdays lost due to injury or illness				
Incident reports				
Patient Satisfaction				
Overall satisfaction				
Finance				
Patient Days vs operating plan				
Operating margin				
Infections				
Urinary Catheter				
-associated urinary tract infection				
Wound Care				

STEP 3

DIAGNOSE

With the Interdisciplinary Lead Team review the 5Ps assessment, Metrics That Matter, and with consideration of your organizational strategic plan, select a first "theme," (www. registry outcome data for improvement.

- The purpose of assessing is to make an informed and correct overall diagnosis of your microsystem.
- First, identify and celebrate the strengths of your system.
- Second, identify and consider opportunities to improve your system.
  - The opportunities to improve may come from your own microsystem—based on assessment, staff suggestions and/or patient and family needs, perceptions, priorities and concerns.
  - The opportunities to improve may come from outside your microsystem—based on a strategic project or external performance/quality measures.
- Look not only at the detail of each of the assessment tools, but also synthesize all of the assessments and Metrics That Matter to "get the big picture" of the microsystem. Identify linkages within the data and information. Consider:
  - Waste and delays in the process steps. Look for processes that might be redesigned to result in better functions for roles and better outcomes for patients.
  - Patterns of variation in the microsystem. Be mindful of smoothing the variations or matching resources with the variation in demand.
  - Patterns of outcomes you wish to improve.
- It is usually smart to pick or focus on one important "theme" to improve at a time, and work with all the "players" in your system to make a big improvement in the area selected.
- Suggestions on how to make your diagnosis and select a theme follow next.

DIAGNOSE YOUR LONG TERM CARE FACILITY

Write your Theme for Improvement _____

"Global" Aim Statement for Theme

Create an aim statement that will help keep your focus clear and your work productive.

We aim to improve _____
(Name the process)

In _____
(Location in which process is embedded)

The process begins with _____
(Name where the process begins)

The process ends with _____
(Name the ending point of the process)

By working on the process, we expect _____
(List benefits)

_____

It is important to work on this now because _____
(List imperatives)

_____

_____

_____

STEP 4

TREAT YOUR CARE CENTER

Draft a clear aim statement and way to measure the aim using improvement models—PDSA (Plan-Do-Study-Act) and SDSA (Standardize-Do-Study-Act).

- Now that you've made your diagnosis and selected a theme worthy of improving, you are ready to begin using powerful Change Ideas, improvement tools, and the scientific method to change your microsystem.
- This begins with making a specific aim and using Plan-Do-Study-Act (PDSA), which is known as the "model for improvement." The improvement model raises three important questions to answer before starting to make changes.
  1. What are we trying to accomplish?
  2. How will we know that a change is an improvement?
  3. What changes can we make that will result in an improvement?
- After you have run your tests of change and have reached your measured aim, the challenge is to maintain the gains that you have made. This can be done using Standardize-Do-Study-Act (SDSA), which is the other half of making improvement that has "staying power."
- You will be smart to avoid totally reinventing the wheel by taking into consideration best known practices, Change Ideas that other clinical teams and patients and families have found to really work. A list of some of the best "Change Ideas" that might be adapted and tested in your clinic follows the aim statement worksheet.

SPECIFIC AIM STATEMENT

Create a specific aim statement that will help keep your focus clear and your work productive.

Use numerical goals, specific dates, and specific measures.

Specific Aim _____

_____

_____

_____

Measures _____

_____

_____

_____

Long Term Care
Example _____

_____

_____

_____

- Once you have completed the assessment and diagnosis of your facility and have a clear theme to focus on, review current best practice and Change Ideas to consider.
- The Change Ideas will continue to develop as more field testing is done and more colleagues design improvements.

LONG TERM CARE FACILITY CHANGE IDEAS TO CONSIDER

1. Meeting to prepare for the day's residents/patients
2. Follow-up phone calls with residents/patients and families
3. Develop and consistently apply algorithms for care
4. Patient and family care conferences to develop short term and long range plans of care
5. Determine risks for adherence to plan of care
6. Utilize registry data and give summary reports to residents/patients and families at each visit
7. Collaborate with resident/patient and family to set goals for care
8. Build an action plan with resident/patient and family for care that is mutually agreed upon and meets the resident's/patient's and family's goals
9. Ask patient and family to set priorities

*Visit http://www.jointcommission.org/HTBAC/LTC/ and www.clinicalmicrosystem.org for actual documents, forms and latest ideas.

Consider the Change Concepts on page 295 of The Improvement Guide by Langley, Nolan, Nolan, Norman and Provost (1996). The main change categories are listed below.

A. Eliminate Waste
B. Improve Workflow
C. Optimize Inventory
D. Change the Work Environment
E. Enhance the Producer/Customer Relationship
F. Manage Time
G. Manage Variation
H. Design Systems to Avoid Mistakes
I. Focus on the Product or Service

Langley G, Nolan K, Nolan T, Norman T, Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 1st ed. The Jossey-Bass Business & Management Series. San Francisco, CA: Jossey-Bass Publishers; 1996: xxix, 370.

Huddle Sheet

- What can we proactively anticipate and plan for in our work day/week? At the beginning of the facility hold a review of today's patient's past visits, review of plans for today, and preview of upcoming days. Frequency of facility review is dependent on the situation, but a mid-day review can be helpful.
- This worksheet can be modified to add more detail to the content and purpose of the huddles.

HUDDLE SHEET

Facility _____ **Date** _____

Aim Enable the facility to proactively anticipate and plan actions based on patient need and available resources, and contingency planning.

FOLLOW-UPS

"HEADS UP" FOR TODAY: (include special patient needs, sick calls, staff flexibility, contingency plans)

Meetings

REVIEW OF NEXT DAY AND PROACTIVE PLANNING

Meetings

Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim. See http://www.jointcommission.org/HTBAC/LTC/ **for examples.**

P*LAN* → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected, over what period of time, to determine if AIM is being achieved?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures

DO → What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?

STUDY → As we study what happened, what have we learned? What do the measures show?

ACT → As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.

The Lead Team should continue to meet weekly to review progress in the design of the PDSA and then during the execution of the test of change in a pilot format to observe and learn about the Change Idea implementation. Remember to always test Change Ideas in small pilots to learn what adaptations and adjustments need to be made before implementing on a larger scale. Data collection and review during the testing is important to answer the question: How will we know if the Change Idea is an improvement?

Once the PDSA cycle is completed and the Lead Team reviews the data and qualitative findings, the plan should be revised or expanded to run another cycle of testing until the aim is achieved.

When the Change Idea has been tested and adapted to the context of the clinical microsystem and the data demonstrates that the Change Idea makes an improvement, the Lead Team should design the Standardize-Do-Study-Act (SDSA) process to ensure the process is performed as designed. During this process it is important to continually learn and improve by monitoring the steps and data to identify new opportunities for further improvement. You will realize you will move from “PDSA” to “SDSA” and back to “PDSA” in your continuous improvement environment. New methods, tools, technology or best practice will often signal the need to return to PDSA to achieve the next level of high performance. You want to be able to go from “PDSA” to “SDSA” and back to “PDSA” as needed. The Scientific method is a two-way street that uses both **experimentation** (i.e., PDSA) as well as **standardization** (i.e., SDSA).

Standardize-Do-Study-Act SDSA

STANDARDIZE CURRENT BEST PROCESS AND HOLDING THE GAINS

STANDARDIZE the process (specify what roles do what activities in what sequence with what information flow). A good way to track and standardize process is through the creation of a Playbook. The Playbook is the collection of process maps to provide care and services that all staff are aware of and accountable for. The Playbook can be used to orient new staff and resident/patient/family advisors, document current processes and contribute to performance appraisals.

DO the work to integrate the standard process into daily work routines to ensure reliability and repeatability.

STUDY at regular intervals. Consider if the process is being "adhered" to and what "adjustments" are being made. Review the process when new innovations, technology or roles are being considered. Review what the measures of the process are showing.

ACT based on the above, maintain or "tweak" the standard process and continue doing this until the next "wave" of improvements/innovations takes place with a new series of PDSA cycles.

S*TANDARDIZE* → How shall we **STANDARDIZE** the process and embed it into daily practice? Who? Does what? When? With what tools? What needs to be "unlearned" to allow this new habit? What data will inform us if this is being standardized daily?

Tasks to be completed to "embed" standardization and monitor process	Who	When	Tools Needed	Measures

*Playbook-Create standard process map to be inserted in your Playbook.

DO → What are we learning as we ***DO*** the standardization? Any problems encountered? Any surprises? Any new insights to lead to another PDSA cycle?

STUDY → As we ***STUDY*** the standardization, what have we learned? What do the measures show? Are there identified needs for change or new information or "tested" best practice to adapt?

ACT → As we ***ACT*** to hold the gains or modify the standardization efforts, what needs to be done? Will we modify the standardization? What is the Change Idea? Who will oversee the new PDSA? Design a new PDSA cycle. Make a PLAN for the next cycle of change. Go to PDSA Worksheet.

STEP 5

FOLLOW-UP

IMPROVEMENT IN HEALTH CARE IS A CONTINUOUS JOURNEY

The new patterns need to be monitored to ensure the improvements are sustained. Embedding new habits into daily work with the use of "huddles" to review and remind staff, as well as weekly Lead Team meetings keeps everyone focused on improvements and results that can lead to sustained and continuous improvements.

Datawalls, storyboards, and monthly all-staff and resident/patient/family advisor meetings are methods to embed new habits and thinking for improvement.

The Lead Team should repeat the process for newly recognized themes and improvements that are identified in the assessment and outcomes/performance metrics.

What	When	Who	Where
Huddles			
Weekly Meetings Lead Team			
Monthly Meetings with All Staff and Resident/Patient & Family Advisors			
Quarterly Reports of Outcomes and Progress			
Annual Retreat for Review and Reflection			
Data Wall			
Storyboards			

CASE STUDY

THE CLOUGH CENTER AT NEW LONDON HOSPITAL

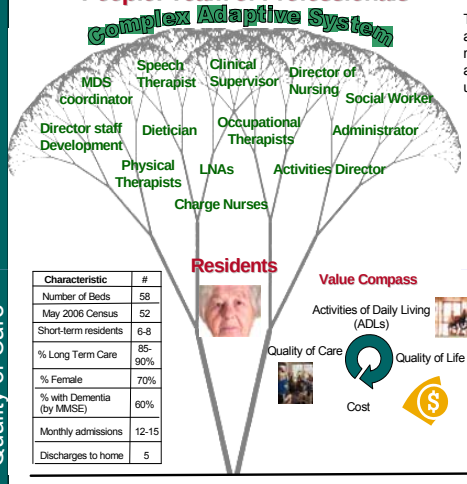
Activities of Daily Living

Reframing Long-Term Care in the Clough Center at New London Hospital

Char Carlson & Sue Mooney ECS 124 Microsystems

Quality of Care

People: Team of Professionals



Characteristic	#
Number of Beds	58
May 2006 Census	52
Short-term residents	6-8
% Long Term Care	85-90%
% Female	70%
% with Dementia (by MMSE)	60%
Monthly admissions	12-15
Discharges to home	5

Residents

Value Compass

Activities of Daily Living (ADLs)

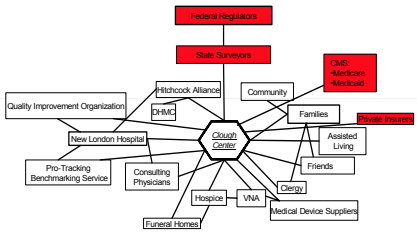
Quality of Care — Quality of Life

Cost

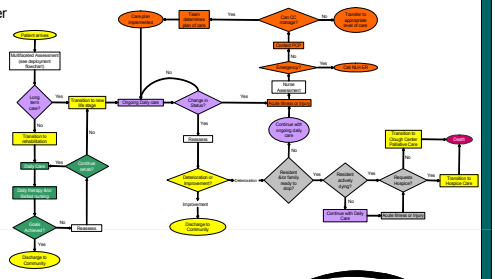
Purpose of Clough

The purpose of Clough is to provide long-term care and short- term skilled nursing and rehabilitation services for residents in nursing home facility. For short-term residents, Clough aims to seamlessly transition residents back to community after acute illness or injury. For long-term residents, Clough aims to prevent unnecessary decline and avoidable events while maintaining quality of life.

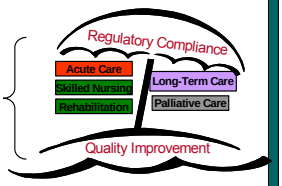
Context – Regulation and Finances Predominate



Core Processes



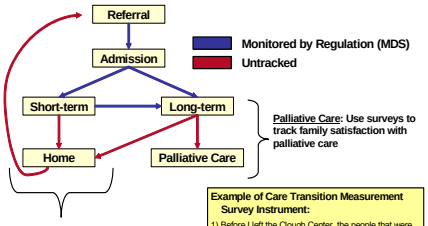
The long-term care industry is heavily regulated. Because of this, all activities at the Clough Center can be seen as falling under an umbrella of Federal and State regulation. As a means to achieving excellent results, Clough Center has chosen to build on a foundation of Continuous Quality improvement.



Options and Opportunities

Become Expert at Managing Transitions:

GOAL: Measure and monitor care processes that affect quality of transitions



Palliative Care: Use surveys to track family satisfaction with palliative care

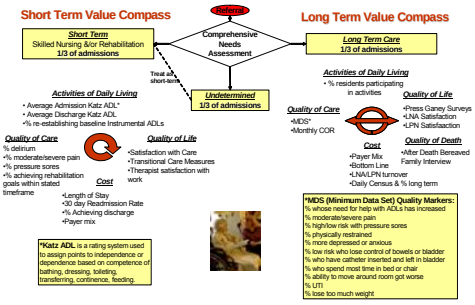
At Discharge: Use surveys to understand resident/family satisfaction with care within facility and ability to manage upon discharge

Example of Care Transition Measurement Survey Instrument:

1) Before I left the Clough Center, the people that were going to help me when I got home clearly understood what my health care needs were.
2) Before I left the Clough Center, I had a phone number I could call day or night to get answers to my questions
3) Before I left the Clough Center, I clearly understood how to take each of my medications.

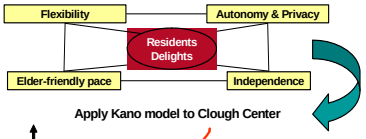
Create short-term rehab wing:

Identify residents at or before admission and tailor process to needs

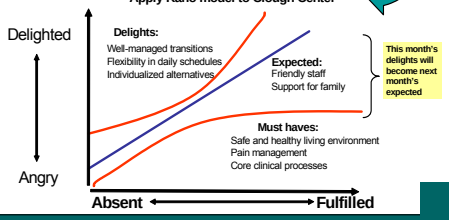


Identify and Cultivate "Delights"

Some of the delights we identified from residents:



Apply Kano model to Clough Center



This month's delights will become next month's expected

Cost

Between Contributing Units in the Microsystem: The "Hand Offs"

Assess the "within" contributing units of your microsystem and the "between" contributing units or "hand offs" in this section.

Contributing units come together to provide care and services to residents/patients. The intentional planning and knowledge of each unit contributes to the overall quality and outcomes of the microsystem.

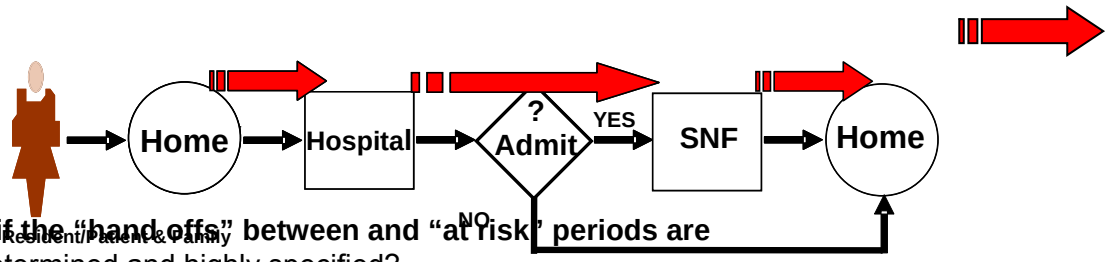
"Hand Offs" Between Contributing Units

An essential element is detailed insight of the "hand offs" of residents/patients, information, data and materials between the contributing units. The "hand offs" between units is one place where errors, omissions, waste, rework and gaps in care can occur. The resident/patient becomes very vulnerable and "at risk" during these hand offs. Your microsystem must commit to designing the process of the "hand offs" between to be highly reliable, defect free, and as pre-determined as possible.

Evaluate Your "Hand-Offs"

Hand-Offs"

Identify the "hand offs" between contributing units that occur within your microsystem. (See diagram)



Evaluate if the "hand offs" between and "at risk" periods are

- Pre-determined and highly specified?
  For example, when your resident/patient is transferred from the long term care facility to the inpatient unit, how are information, medication orders, and plan of care including resident/patient and family preferences communicated?

Convene the contributing units to focus on "hand offs."

- What are resident/patient and family perceptions on hand-offs? What's helpful? What isn't helpful? What would they improve?
- How do we currently "hand off" residents/patients, information, data and materials?
- Have we ever discussed what the receiving unit requires in a standard way?
- Have we ever determined what WE need to receive in a standard way from units who "hand-off" to us? Have we communicated this?
- Is there one direct way to send residents/patients, information, data and materials?
- Is the hand off process pre-defined, highly specific, simple, and direct without loops and rework?
- Are there regular opportunities to provide feedback about the hand off process from the sender and receiver?
- Do we meet on a regular basis to review our entire microsystem?

Based on the exploratory discussion, design how to improve the hand offs toward the goal of being defect free, highly reliable, predictable and simple.

Consider the 4 Rules for Design when developing improvement strategies

"Hand Offs" 4 Rules for Design [Δ]

1. All work must be highly specified as to content, sequence, timing, location and expected outcome.
2. Every customer-supplier connection must be highly specified, direct, and there must be an unambiguous yes-or-no way to send requests and receive responses.
3. The pathway for every product and service must be predefined, highly specified, simple, and direct with no loops or forking.
4. Any improvement must be made in accordance with the scientific method, under the guidance of a teacher, at the lowest possible level, aiming toward the ideals.

Δ www.prhi.org Visit www.ihi.org and www.clinicalmicrosystem.org for the latest ideas

FRAMEWORK FOR RESIDENT/PATIENT &
FAMILY INVOLVEMENT IN A LONG TERM CARE FACILITY*

The following represents a framework for ways to think about including residents/patients and families in long term care work. Overall, the table is divided into different levels of resident/patient and family involvement. The suggestions build on each other, i.e., the ways in which residents/patients, families and/or staff might prepare within one level assumes the preparation included at all previous levels as well as that particular level. Examples of specific resident/patient or family responsibilities are listed at each level. These lists are not comprehensive, but examples of what patients or family members' responsibilities might be.

Residents/Patients/Families Roles[1]	**Resident/Patient/Family Responsibilities**	**Staff/Healthcare Providers Responsibilities Preparation/Compensation**
Residents/Patients or Families as Participants • Respond to surveys and questionnaires • Focus group member	• Family perceptions of care and quality are elicited and used in shaping improvement initiatives. • Data/information from families is used in measuring improvement. • Responsibilities end when their input is received unless they are asked to provide feedback on the interpretation of the data. • Review and give feedback related to materials developed specifically for patients or families, e.g., educational materials. • Provide suggestions for improvement in writing as appropriate. • Respond to surveys/questions openly and honestly.	PREPARATION: • All efforts should be made to ensure that residents/patients and families real experience is accurately measured and interpreted. • Attention is focused more on the instruments, methods, and analysis than on significant patient or family participation, training or preparation of them as participants (beyond what is necessary for them to make an informed choice to participate and to complete the activity). • In keeping with a resident/patient/family-centered approach, efforts to ensure that all (or an adequate sample that reflects the diversity of populations served) are included. COMPENSATION: • Acknowledgement of appreciation for their participation is necessary. • Supplying residents/patients/families with a summary of the data and information about how the data is/will be used to improve area of focus (e.g., quality care, education, etc.). This can occur in a resident/patient/family meeting, education day, written summary, etc and may be additional compensation.

Residents/Patients/Families Roles[1]	Resident/Patient/Family Responsibilities	Staff/Healthcare Providers Responsibilities Preparation/Compensation
Patients or Families as Advisory Board Members[2] • Members of committee • Member of task force • Residents/Patients or families serve on advisory boards for the quality improvement team.	• Responsibilities will depend on level of involvement of the advisory board. o If the advisory board is used to review policies, programs, and evaluation methods after staff has written them, there are few opportunities for teamwork. o If the advisory board assists in the planning, implementation and evaluation of improvement projects, education materials, etc. then its responsibilities will be much greater and they will be viewed as more of a partner than advisor/reviewer.	PREPARATION: • The most effective resident/patient/family advisory boards have established means for recruitment, selection, membership requirements, setting bylaws, as well as ongoing strategic planning that identifies goals, activities, and evaluation. Support for these boards can be space for meetings, or administrative support (e.g., mailings, secretarial support, printing costs, etc.). • Staff members are identified to serve as liaisons to the advisory boards (and their time is covered by the unit/hospital) in order to build communication, coordination, and partnership. COMPENSATION: • Care centers can show their commitment by providing the advisory board regular opportunities for the board to report to senior leadership and/or to participate within a shared governance model. • The more involved the residents/patients and families are in the planning, implementation and evaluation: the more there is a building of a partnership rather than just giving the “rubber stamp” approval of an activity. • Other preparation issues to consider include childcare, meetings that include meals, parking and other transportation costs, and stipends for participation. REFERENCE: 1. Webster PD, Johnson BH. *Developing and Sustaining a Patient and Family Advisory Council.* Bethesda, MD: Institute for Family-Centered Care; 2000.

Residents/Patients/Families Roles[1]	Resident/Patient/Family Responsibilities	Staff/Healthcare Providers Responsibilities Preparation/Compensation
Residents/Patients or Families as Active Advisors /Consultants[3] • Active task force/committee members • Faculty for staff education • Participants at collaborative meetings/ conferences • Mentors others in work (residents/patients, families or staff) • Trainers for other patients and families involved • Orientation of staff • Work closely with the quality improvement team	• At this level, residents/patients/families have a continuous and more active involvement with the care center, e.g., quality improvement team, educational materials. • Service time is usually clearly limited, e.g., 2-3 years or whatever is agreed upon by the care center, resident/patient &/or family member. • They would be active participants as members of the teams who are planning, implementing and evaluating either individual projects and/or the work of the collaborative team as a whole. • Help in the quality improvement effort, all components of the Plan, Do, Study, Act (PDSA) cycle	PREPARATION: • In order for residents/patients and families to participate at this level, training, preparation and support would be comparable to what the staff receives. They require training specifically in the area of responsibility, e.g., quality improvement model and processes. Consider joint training sessions with residents/patients, families and staff. • Expectations for involvement would be defined and regularly reviewed. In addition, this level would also require that teams receive training in working collaboratively with residents/patients and families.[4] • Experienced staff, residents/patients and/or families can serve as experienced trainers and mentors for others. COMPENSATION: • Determine how staff, residents/patients and families will be compensated and provided the means to participate at meetings. Consider reimbursement for time and travel. Don't forget to plan for other issues such as childcare, transportation costs, parking, meals. • Commitment by the care center and value of the patient/family input is demonstrated through the continuing funding of resident/patient and/or family participation.

Residents/Patients/Families Roles[1]	Resident/Patient/Family Responsibilities	Staff/Healthcare Providers Responsibilities Preparation/Compensation
Residents/Patients and/or Families as Co-Leaders • Facilitator • Content expert • Evaluator[5] • Author • Hospital/clinic employee	• A high level of involvement patient and/or family. • Adequate skills and knowledge is required. • Previous work/education in focused content (e.g., QI, healthcare) is very valuable. • Consider community leadership experiences when choosing members to bring a different perspective and an awareness of other community needs. • Experiences serving in any of the previous outlined roles may provide the necessary knowledge without professional or educational.	PREPARATION: • This level requires all of the preparation included in all previous levels of involvement as well as additional preparation related to how to effectively collaborate with clinic/hospital leaders/administration. • Supervision and evaluation of those involved should be formalized. • Consider employing residents/patients and/or families as clinic/hospital staff because of the requirements, commitment, and role expectations of the co-leaders. • Intensive training and support for patients, families and staff who participate at this level should be developed. Consider participation in retreats, on-site coaching, even off-site training and evaluation. COMPENSATION: • Determine how staff, residents/patients and families will be compensated and provided the means to participate at meetings. Consider reimbursement for time and travel. Don't forget to plan for other issues such as childcare, transportation costs, parking, meals.

These resident/patient and family role ideas are based on work from the Vermont-Oxford Network. Mutual trust and respect must be built no matter what level people are serving in or whether they are staff, a resident/patient or family member. This takes time. As residents/patients and families are offered more opportunities to participate, the time spent in building an understanding of individual areas of expertise and common goals will help strengthen a team's capacity to collaborate and further partnership in improving long term care. This will require integration of team building activities while building the partnership between residents/patients, families and care centers.

Notes:

[1]The framework for the roles was adapted from an article on participatory action research by Turnbull, Friesen, Ramirez, 1998 (see references).

[2]For a comprehensive resource on family advisory boards, refer to Webster, Johnson, 2000 (see references).

[3]Refer to Dillon, 2003 (see references) for guidance on parent participation on quality improvement teams.

[4]Refer to Jeppson, Thomas, 1995, 1997 and Turnbull, et al., (see references).

[5]For an annotated bibliography of families serving on evaluation teams refer to Jivanjee, et al., 2004 (see references).

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RESIDENT/PATIENT & FAMILY INVOLVEMENT BEYOND CLINIC*

There are countless ways that residents/patients and families can participate in care. They can serve as advisors, help with orientation of staff, education, quality improvement and in making connections with others. Some are formal and ongoing, others are time limited and informal. At other times, it may be important to seek patients' and families' input on one specific issue. All are necessary to ensure that health care is truly responsive to the needs, priorities, goals, and values and their families. Below is a list of some of the ways that residents/patients and families can be involved in their facility.

Education

- Have residents/patients and families involved in planning, developing &/or revising educational materials.
- Involve residents/patients and families in the development of center's web site
- Ask residents/patients and families to assist in translating patient information materials, e.g., into another language, or making information understandable to others.
- Have families and residents/patients involved in planning, developing and presenting at facility's Family Education Day.

Quality Improvement

- Include resident/patient and family in benchmarking visits to other programs. Get their idea of what can be improved at your care center.
- Develop, with resident/patients and families, a consumer satisfaction survey and involve them in developing the responses to issues and problems identified, i.e., start with the satisfaction survey in "Assessing Your Practice."
- Keep suggestion forms in waiting rooms, so families can record their ideas. Allow opportunity for suggestions to be submitted anonymously either in the clinic or by mail if desisted.

Orientation

- Invite residents/patients or families to present at staff orientation and inservice programs.
    - Have them present care needs of the resident/patient/family
    - Presentation concerning infection control
    - Snacks and nutritional needs met – inpatient/outpatient
- Ask residents/patients or families to host a dinner for a professional-in-training.
    - New residents, fellows, medical students
    - New nurses, therapists, social workers, both inpatient and outpatient
- Have resident/patient/family orientation for people new to care center – either moved to the center or transitioned pediatric to adult.

Making Connections

- Newsletter about care center happenings – written and produced by residents/patients/families.
- Hold a monthly/regular family/staff coffee hour.
- Create peer mentor or family liaison positions, e.g., for newly diagnosed, first hospitalization.
- Create regular opportunities (e.g., monthly meetings, coffee hours) for residents/patients and families to talk with department heads or the senior management team.
- Ask residents/patients and families to join the health care providers when they meet with local, state or federal government representatives, funders, or other community groups.
- Conduct follow-up phone calls with residents/patients and families after hospital discharge; or as consented, have a resident/patient or family member call the person who was discharged (or their family) as a mentor post-hospitalization.
- Set up "exit interviews" with administrators when residents/patients and families are leaving the hospital or transferring to another facility.
- Support groups

Advisory Council

- Create an advisory council with residents/patients and families to provide input and direction to clinic work, e.g., QI activities, educational materials, support network.
- Have a resident/patient/family task force that reviews suggestions or is a contact for others for suggestions/issues/comments. This task force works closely with the professional care providers to make change.
- Appoint residents/patients and families to task forces and work groups related to clinic flow, quality improvement, infection control processes, renovations when occurring, admitting procedures, discharge planning, patient safety, pain management, and other continuous quality improvement endeavors.
- Convene focus groups of residents/patients and families as specific issues arise. Have the task group members serve for a specific amount of time.

*Adapted from Jeppson, E. & Thomas, J. (1994). *Essential Allies: Families as Advisors.* Institute for Family-Centered Care, Bethesda, MD. Revised 2005.

Additional resources available through the CF Foundation (www.cff.org) or the Institute for Family-Centered Care (www.familycenteredcare.org):

Webster, P. D., & Johnson, B. H. (2000). *Developing and Sustaining a Patient and Family Advisory Council;* Blaylock, B. L., Ahmann, E., & Johnson, B. H. (2002). *Creating Patient and Family Faculty Programs*.

Patient and Family Involvement

The patient and family are integral to the clinical microsystem. Involving patients and families in improvement activities with the clinical improvement Lead Team will result in innovations and remarkable improvements in patient care and outcomes. The following patient and family involvement guidelines are based on the Institute for Family Centered Care www.familycenteredcare.org and the Vermont Oxford Network (http://www.vtoxford.org/) experiences.

TIPS FOR INVOLVING PATIENTS AND FAMILIES ON COMMITTEES AND TASK FORCES

- SELECTING PATIENTS AND FAMILIES TO SERVE AS ADVISORS
  - Look for people who are
    - Interested in serving as advisors
    - Comfortable speaking in a group with candor
    - Able to use their personal experience constructively
    - Able to see beyond their own experience
    - Concerned about more than one issue or agenda
    - Able to listen and hear differing opinions
    - Representative of patients and families served by the clinic/hospital
  - Strive for patients and family members to be one-third to one-half of the membership. Having just one patient or family member on a committee is not sufficient.
  - Serving as a patient or family advisor is a new role for many. Patients and family members differ in their need for support and mentoring in order to grow and develop in this new role.

- PREPARE FOR MEETINGS
  - Consider the availability and commuting issues of patients, families and health care providers when planning the times and locations for meetings.
  - Provide a list of committee members with contact information, a brief description of who each person is and how each person relates to the clinic/hospital. (Some groups include digital pictures.)
  - Send agenda and minutes in-advance to all committee members. Allow time for materials to be mailed and time to be read by patients and families (they may not have email, faxes etc.).
  - Offer a mentor, an experienced patient or family advisor or another committee member, to serve as support for a new advisor.
  - Provide an opportunity and support for a new member to talk through and discuss the processes, their new role and potential change in interaction with either staff or patients and families.
  - Offer to have the new member bring someone who is familiar to the first few meetings.
  - Remember that this type of collaboration is new for many people so preparation and orientation is important for staff as well as patients and family members.
  - Plan for compensation of time, expertise, and expenses for ALL participants.
  - Designate one staff member to be responsible for reimbursement and other practical or logistical issues for patient and family advisors.

- DURING MEETINGS
  - Use effective meeting skills
  - Spend extra time on introductions at the beginning of every meeting, especially for a new committee or when there are new members.
  - Provide clear information about the purpose of the committee or task force and the roles of individual members.
  - Consider beginning some meetings with a brief story that captures patients' and families' experiences and perceptions related to topics to be discussed.
  - Avoid using jargon. Explain technical terms when used.
  - Ask for the opinions of everyone during discussions, encourage patients and families participation to validate their role as valuable members.
  - To avoid becoming stuck in the power of a negative situation, acknowledge the negative experience and ask if there was anything supportive, helpful, or positive for the group to learn from the situation. Ask for ideas and suggestions to prevent or improve the situation.
  - If a personal story becomes very prolonged, acknowledge the power and importance of the story, suggest that some policy implications can be learned from the story and that there may be other more appropriate forums where this story should be shared.
  - When there are extreme differences in opinions or perceptions, consider
    - Appointing a task force for further study of the issue;
    - Asking the opinion of other groups (such as, another hospital committee or patient/family advisory group); or
    - Delaying a decision and consideration at a future meeting.
  - First meeting discussions–these may need to be repeated on an as needed basis.
    - The concept of collaborating with patients and families explicitly, recognizing that it is a process with everyone learning together how to work in new ways. Convey that it will be important for the group to discuss how the process is working from time to time.
    - Acknowledge that there will be tensions and differing opinions and perceptions.

- ANTICIPATE ILLNESS DEMANDS
  - Patients and their family members may not be able to attend every meeting. There are other demands on their time and stamina.
  - Creating a variety of ways for patients, families and staff to participate in the meeting without being physically present (e.g., conference calls, written review of materials).
  - Acknowledge to patients and families themselves and to the committee as a whole that their presence was missed and their participation is valued when they are able to participate. Mailing the minutes and future agendas helps reinforce that their participation is valued.
  - Having shared memberships on the committee may help.

Additional guidance resources are available through the CF Foundation (www.cff.org) or the Institute for Family-Centered Care (www.familycenteredcare.org).

1. Webster, P. D., & Johnson, B. H. (2000). *Developing and Sustaining a Patient and Family Advisory Council;*
2. Blaylock, B. L., Ahmann, E., & Johnson, B. H. (2002) *Creating Patient and Family Faculty Programs*;
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IMPROVING PATIENT AND FAMILY INVOLVEMENT IN THE CF CARE CENTER AT ARKANSAS CHILDREN'S HOSPITAL THROUGH DEVELOPMENT OF A FAMILY ADVISORY BOARD

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INTRODUCTION: The CF Care Center at Arkansas Children's Hospital established a multidisciplinary CF Leadership Team in July 2005 to improve CF care in the areas of patient care, education, research, QI initiatives, patient and family support, and advocacy. Family perceptions of care and quality are an important aspect of this objective. Our current level of family involvement has been intermittent receiving input only as requested through various surveys, questionnaires, and parent attendance at annual Parent Resource events. The ideas of transparency of Long term care facility data and partnership with families were presented during the annual Parent Resource day held in Sept. 2005. The CF team set a goal to establish a Family Advisory Board (FAB) to assist with design and implementation of pilot projects, educational material, family support services, and active participation within the Long term care facility as a whole.

METHOD/STRATEGY: The CF team identified 70 dependable family members, half of our center's total patient population. The selected group was mailed a letter of invitation, a job description outlining responsibilities of a FAB member, and an application. Candidate applications were reviewed by members of the CF team. Twelve members and four alternates were selected as the first FAB ensuring broad representation of a variety of patient ages, geographical locations from within the state, and Long term care facility physicians. The four alternates are spouses of FAB members. The currently identified major goals of our Long term care facility are:

- To offer ideas and suggestions regarding policy and practice affecting family centered care.
- To review recommendations and concerns as referred by other parents, staff, physicians, and/or administration.
- To serve in an educational role, as needed or requested, regarding patient/family perception of care and services.
- To assist in the planning and implementation of new services/processes as requested by Long term care facility staff.

CONCLUSION: Our Long term care facility is committed to family-centered care and wants to ensure the needs of our patients and their families are considered and met. The purpose of our FAB is currently to serve as an advisory resource committee to the CF Care Center providing constructive input and assistance as the Long term care facility seeks to continually improve. The initial meeting was held March 25, 2006 to introduce the selected members to each other, complete a hospital orientation, and to establish the policy for the FAB. The next step will be incorporating the FAB in our Long term care facility's QI activities and developing a working relationship between the FAB and current CF team.

GLOSSARY

Clinical Microsystems
Aims
Processes
Shared information
Environment
Performance outcomes
Contributing units
Purpose
Processes
Patterns
Patients
Professionals
Define the 5Ps
Daily huddles
Metrics that matter
Redesign
PDSA (Plan, Do, Study, Act)
SDSA (Standardize, Do, Study, Act)
Measures
Compilation
Aim
Point of service
Flowchart
Patient cycle time tool
Core and supporting processes evaluation
Run tests of change

PDSA Cycle worksheet
Process mapping
Rework
Leadership
Social pattern
Vital performance characteristics
Data wall owner
Data wall
Balanced set of metrics
Operational definition
Data owner
Target value
Action plan
Time trend charts
Bar charts
Quality measures
Patterns of variation
Patterns of outcomes
Global aim statement
Tests of change
Change ideas
Specific aim statement
Playbook
Process maps
Measures of the process
Standard process map
Hold the gains
Storyboards
Quarterly reports of outcomes and progress

Annual retreat for review and reflection

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