



TL3EO – The CNO influences organization-wide change beyond the scope of nursing.

Provide 1 example, with supporting evidence, of a CNO-influenced positive change that had organization-wide impact beyond the scope of nursing services. Supporting evidence must be submitted in the form of a graph with a data table that clearly displays the data.

Example: Improvement in Equipment Delivery Times

Background/problem:

Delivery times for patient care equipment from our central Equipment Pool were consistently higher than desired for timely patient care. Items such as intravenous pumps, bedside commodes, and sequential compression devices are integral to basic patient care in all inpatient units. Our system of storage, cleaning, and delivery was not keeping up with demand. Feedback from RNs, therapy services and other patient care staff, Be Safe event reports, coupled with employee engagement results highlighted this specific need. Organizationally, the employee engagement scores for the Gallup question “I have what I need to do my job right” were below national benchmark at the 33rd percentile rank. As leadership engaged in problem solving on system issues, Lorna Facteau, DNSc, RN, Chief Nursing Officer, identified these system deficits as a priority. Facteau partnered with Environment of Care Chief Tom Harkins and Chief Operating Officer Bo Cofield to charge a leadership team to improve this system.

Goal Statement:

Reduce and sustain pooled equipment delivery times.

Description of the Intervention/Initiative/Activity(ies):

Improvement Initiative Team Formation:

Facteau and Harkins chartered the project team in January 2014 to assess and address the current state of the pooled equipment delivery system.

Among the many operational priorities for medical center leadership, Facteau was instrumental in framing the need for rapid action in this domain around the care and treatment delays related to lack of timely equipment access. She was able to highlight evidence from the AONE White Paper on Support Services¹ in which RN staff must “pick up the slack” for low performing support systems in hospitals, thereby draining

¹ The American Organization of Nurse Executives (AONE) and Aramark Healthcare. White Paper: Creating a Culture of Collaboration Between Nursing and Support Services in the Clinical Setting. http://www.aone.org/resources/leadership%20tools/PDFs/White_Paper_Final%2032409.pdf



precious minutes on a daily basis that could otherwise be invested in improving patient care outcomes. Using the results from the October 2013 AONE Nursing Support Services Survey, she was persuasive with her colleagues in demonstrating that this phenomenon was occurring in our facility with pooled equipment. In addition to the invisible drain on nursing time to meet equipment needs, lack of a functioning support system was a key driver in sub-optimal employee engagement scores for inpatient RNs. A key directive from Dr. Facteau to the redesign team was that RN and PCA/PCT staff from the units not be required to leave the unit to get equipment; the new system and process needed to include equipment delivery to the user.

The project team was co-led by Holly Hintz, MSN, RN, NE-BC, Director, Nursing Governance and Rudy Beverly, Manager, Patient Logistics and Support Services, with support from health system Management Engineering. An interdepartmental leadership team was assembled to guide the in-depth assessment and generation of solutions beginning in spring 2014. Front line staff, manager, and leadership interviews were conducted to frame the current state for both the equipment pool and the larger equipment management system of which it is a part. Team members conducted observations and collected data in the patient care areas to fully understand the contributing factors. This careful evaluation process revealed that the issues with our equipment pool were a part of larger systems issues within our medical center's entire approach to equipment management from acquisition through logistics. The team diligently mapped these contributing factors in order to fully portray our long-term system needs.

The team updated Dr. Facteau and Mr. Harkins regularly. All agreed that while the larger issues required long-term attention, the immediate need was improving delivery time and reducing delays in delivery of pooled equipment through re-design of the system. Facteau and Harkins supported the team's recommendation to decentralize equipment pool delivery from the hospital basement to equipment "depots" on the patient care floors.

Sixth Floor Pilots Decentralized Equipment Depots:

Dr. Facteau authorized the conversion of scarce common storage space near patient care units to house the equipment depots. Our management engineering partners worked with all system stakeholders to build a functioning delivery and cleaning model in the equipment depots, affiliated with the larger Equipment Pool in the basement. This included a successful funding request for additional dedicated Equipment Depot Delivery staff. Lean principles were applied in set up of the depot room, delivery processes, and daily leadership rounds. Facteau directed that the pilot of the new model be focused on the hospital's 6th floor units, and the pilot launched October 1, 2014. Based upon our experience with this pilot, the Chiefs group would determine how to move the new approach across the entire medical center.



Partnership with interdepartmental managers and staff was critical to success of the new model. Holly Hintz worked with nursing unit, physical ,occupational, and respiratory therapy managers, and our Environmental Services (EVS)management team to frame the project and staff's role in smooth functioning. She led communication and follow up efforts, bridging with interdepartmental partners and keeping Dr. Facteau updated. Unit administrative assistants, who work closely with health unit coordinators and patient care staff in each unit, played a primary role in supporting the project and helping fine-tune the approach. Interdepartmental enthusiasm at all levels was evident and front line staff members were delighted with initial results.

The new model focused equipment items and delivery staff closest to our patients. This reduced wasted time in elevators and increased the "in use" time for our equipment items. Staff changed practice to more regularly remove unused equipment from patient rooms to keep it circulating in our system. As they gained experience with consistently improved delivery times, "hoarding" behaviors began to dissipate in the pilot units. Managers were excited about the quick results and diligently worked with day-to-day issues to keep the units on track. The Equipment Pool leadership partnered with front line staff and nurse managers to iron out issues and continually improve performance details. Occupational and physical therapy leaders reflected the therapists' increasing satisfaction with timely availability of items they needed to treat their patients such as IV poles, chair alarms, and bedside commodes. EVS supervisors and staff expressed positive feedback about the project's impact on decompressing unit soiled utility rooms due to faster equipment pick up. This made it easier for EVS staff to meet our standard of placing soiled utility equipment in the soiled room rather than in front of it.

The improvement in delivery times was dramatic for the initial pilot units. Delivery performance (from request to completion) improved from a baseline average of 42 minutes to 13 minutes.

The initial sixth floor pilot unit success impacted the organizational wide equipment delivery times. The depot model decompressed the central equipment room and allowed for more efficiency in closing requests for equipment. Each additional unit depot that opened further improved the central equipment room's ability to meet the requests efficiently.

Expanding Equipment Depots Based On Pilot's Success:

Based on these results, Facteau championed and with Harkins, jointly approved an expansion of the pilot to the 5th floor. The second pilot was launched December 3, 2014 and successfully tested the model's ability to ramp up efficiency using the same depot team for two floors. The same sustained improvement has been documented on the second pilot floor. Performance data is tracked daily and reviewed weekly with managers, staff, and administrative assistants.



The project team submitted a business plan to address the full range of equipment management needs in February, 2015. This plan, requested by Facteau and Harkins, maps out investments needed at a variety of levels to improve the functioning of all aspects of our equipment system from acquisition, to storage, to logistics, and maintenance. Along the way, Facteau and our PNSO Cabinet have kept nurse managers and nursing staff apprised of these improvements. Positive interdisciplinary staff comments have been abundant in leadership rounding.

The investment in resources, primarily seven full time Equipment Depot staff to improve this delivery performance, has required our Chiefs group to prioritize this project among many deserving efforts across our system. Facteau has been an effective champion of these results' positively benefitting our patients, and in turn our staff's ability to provide the care they want to be providing. She and Harkins have together expressed our need to invest these resources to improve care delivery to our patients.

As a result of this advocacy, further expansion of this pilot was approved, and the existing funding extended through the end of fiscal year 2015. Equipment depots and additional delivery staff were launched mid- March 2015, covering 21 of the 30 inpatient units of our facility. The remaining units are experiencing improved delivery times as well due to the decompression of the central delivery system and evaluation for further improvement is ongoing.

Participants:

TL3EO Table 1. Participants, Decentralized Equipment Depot Project

Name	Discipline	Title	Department
Lorna Facteau	Nursing	Chief Nursing Officer (co-sponsor)	Patient Care Services
Tom Harkins	Environment of Care	Chief Environment of Care (co-sponsor)	Environment of Care
Holly Hintz	Nursing	Director, Nursing Governance Programs; project team co-lead	Patient Care Services
Rudy Beverly	Patient Logistics	Manager; project team co-lead	Environment of Care
John Daly	Equipment Management	Supervisor	Environment of Care
Barry Wagner	Management Engineering	Manager	Management Engineering
Mike Friesen	Biomedical Operations	Director	Biomedical Operations
Jeff Trice	Management Engineering	Senior Management Systems Engineer	Management Engineering

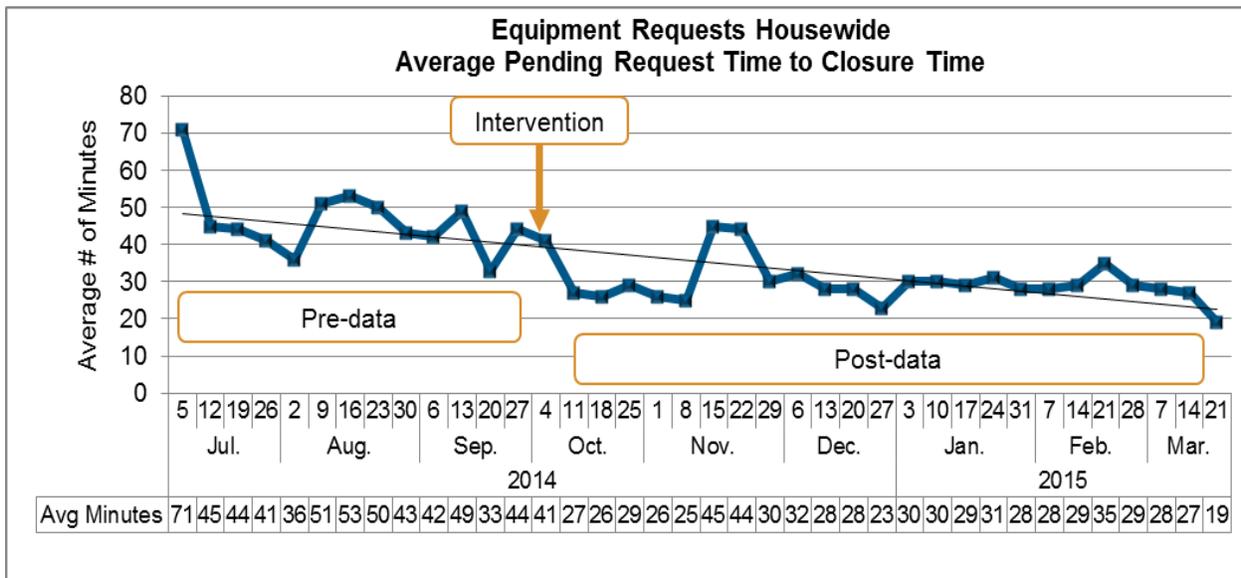


Andy Poole	Therapy	Director	Therapy Services
Chad Gibbs	Respiratory Therapy	Manager, Respiratory Therapy	Therapy Services
Barbara Strain	Value Management & Analysis	Director	Supply Chain
Susanna Brent	Marketing & Communications	Director	Marketing & Communications
Tony Caswell	Environmental Services	Director	Environment of Care

Outcome(s):

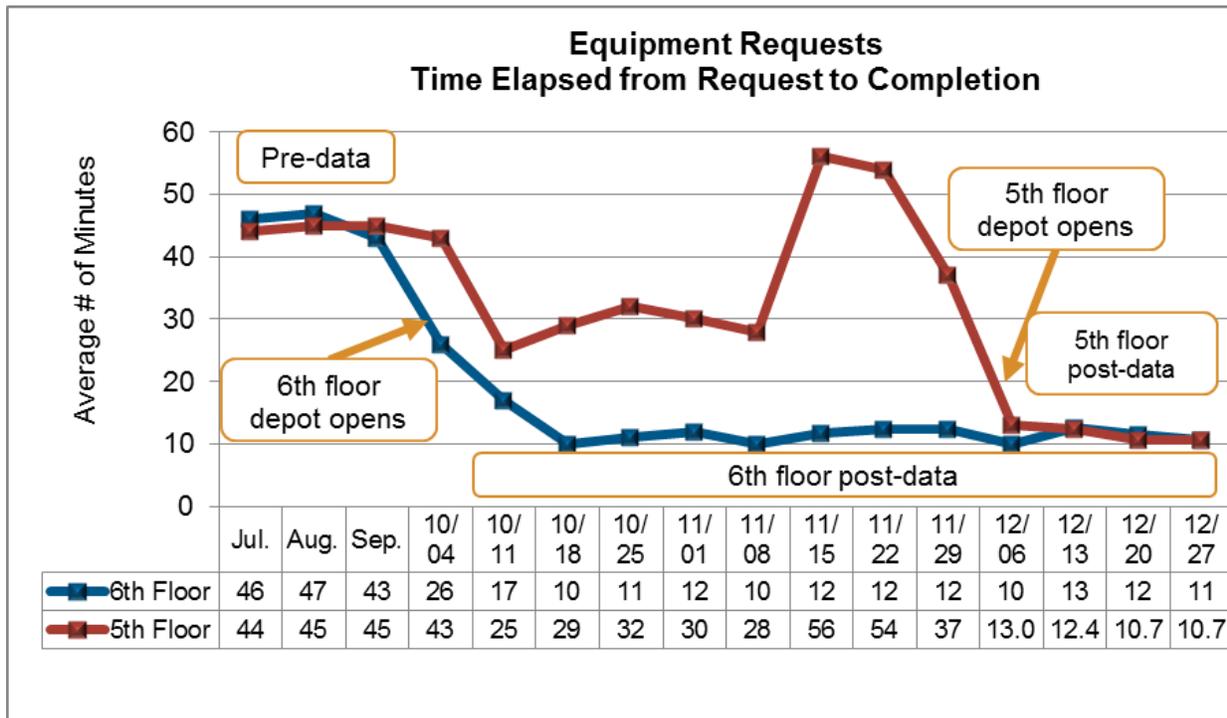
As a result of this system-wide redesign, equipment delivery times measured by pending request to closure of the request, have steadily improved.

TL3EO Figure 1. Equipment Requests Housewide: Average Pending Request Time to Closure Time (July 2014-March 2015).





TL3EO Figure 2. 5th and 6th Floor Equipment Requests: Average Pending Request Time to Closure Time (July 1, 2014- December 27, 2014)



Deficient Example (Not Accepted by the ANCC): Hand Hygiene Compliance

Background/problem:

Hand hygiene is a priority for all hospitals. It is important to protect all staff members and patients from infection, and cleansed hands are the best way to achieve this goal. UVA monitors hand hygiene compliance through observational audits conducted by unit staff and independent Infection Prevention and Control observers of all individuals within the patient care environment, including clinicians and support staff. The results are combined for a final rate and reported on the Medical Center Quality Dashboard.

The Hand Hygiene Workgroup provides focused oversight to the hand hygiene rates. This group reports to the Infection Prevention and Control committee which reports to the organization’s Quality Committee. Lorna Fecteau, DNSc, RN, CNO is a voting member of the Quality Committee. In late 2011 and the first quarter of 2012, hand hygiene rates were lower than desired. Despite many efforts, initiatives and campaigns to improve, these rates remained too low.



Clinical nurses and other direct care providers reported that there were not enough of the waterless alcohol hand gel (Purell) dispensers and they were placed in locations that were not in the routine work flow of patient care.

Goal Statement:

Improve hand hygiene compliance rates through the increase in the number and improved locations of waterless hand hygiene dispensers.

Description of the Intervention/Initiative/Activity(ies):

Facteau received feedback from clinical nurses, Infection Prevention and Control Committee members and other team members that the inadequate number and poorly placed dispensers were a barrier to hand hygiene improvement. As a member of the Quality Committee, she participated in the discussion held in the April 12, 2012 meeting about the hand hygiene rates. This issue was also addressed in the Patient Care Committee co-chaired by Facteau and the Chief Medical Officer.

Facteau supported the Hand Hygiene Workgroup and the Infection Prevention and Control Committee to acquire more dispensers, however, the total volume of the gel, and therefore number of dispensers, was limited by fire code.



Lorna Facteau, DNSc, RN, Chief Nursing Officer (center) with fellow nurses.

Facteau met with the Fire Marshall in late April to discuss the fire code and explore any potential flexibility. He explained that the total volume of the Purell, as a flammable liquid, was limited per fire zone and that the number of dispensers could not be increased without exceeding the acceptable volumes.

Donna Hollis, BSN, RN, Infection Preventionist RN and Chair of the Hand Hygiene Workgroup, explored possible alternatives to increase the number of dispensers. She found that if the organization switched from gel to foam and reduced the volume of the bags in the dispensers, the number of dispensers could be greatly increased without breaking the fire code for allowable volumes of flammable liquids within a fire zone.

Facteau began advocating for this increase in dispensers. She engaged the help of nursing leader Holly Hintz, MSN, RN, NE-BC, to partner with Hollis and help coordinate the logistics of mapping and planning installation of the new dispensers. Once a plan was developed, it was presented to the Patient Care Committee in May 2012 and approved with Facteau's strong endorsement. The plan was approved by committee vote.

Hintz and Hollis then worked with physical plant and our facilities department leaders to guide the installation of the new dispensers. Dispensers were added at the doorway to



patient rooms and in between beds in semi-private rooms. Installation was complete by the end of June 2012. Team members of all disciplines immediately offered positive feedback on the new dispensers.

Participants:

TL3EO Table 1. Participants, Hand Hygiene Dispenser Expansion

Name	Discipline	Title	Department
Lorna Facteau	Nursing	Chief Nursing Officer	Patient Care Services
Donna Hollis	Nursing	Infection Preventionist RN	Infection Prevention and Control
Holly Hintz	Nursing	Director, Nursing Governance	Patient Care Services
Eve Giannetta	Nursing	Manager	Infection Prevention and Control
Christie Piedmont	Nursing	Infection Preventionist	Infection Prevention and Control
Kevin Fox	Facilities	Administrator, Facilities Planning and Construction	Facilities Planning and Development
Bill Rockwell	Engineering	Health System Engineer	Facilities Management

Outcome(s):

Facteau's successful advocacy of the addition of more dispensers combined with improved placement resulted in an increase of overall hand hygiene compliance. Figure 1 represents the hand hygiene compliance for all disciplines and team members.



TL3EO Figure 1. Hand Hygiene Practices: Percent Compliance (2Q11-2Q13)

