Making It Meaningful: Finding Quality Improvement Projects Worthy of Your Time, Effort, and Expertise

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As the nurse manager of the trauma intensive care unit, you have just received the most recent patient satisfaction scores, and they are still below the preferred institutional benchmark. The lowest scoring items are (1) staff effort to include patients/families in decisions about treatment, (2) how well nurses kept patients/family informed, and (3) the amount of attention paid to the patient’s special or personal needs. At the next team meeting, you invite your staff to offer suggestions on how to improve satisfaction scores. A lively discussion erupts, with some nurses recommending a research project and others a quality improvement (QI) project. Using published guidelines,1 the group decides to use current evidence-based knowledge and best practices applicable to their patient population that will address the identified deficiencies (QI) versus trying to generate new knowledge or

CE Continuing Education

This article has been designated for CE credit. A closed-book, multiple-choice examination follows this article, which tests your knowledge of the following objectives:

1. Describe how to determine process improvement priorities
2. Review the use of process improvement methods that will work for your facility
3. Review patient safety strategies and initiatives endorsed by the Agency for Healthcare Research and Quality to prevent harm

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interventions (research). One team member volunteers to initiate a literature search related to patient satisfaction scores and evidence-based interventions for intensive care units while another offers to contact a nurse manager of a similarly sized trauma unit at a different institution who consistently has high patient satisfaction scores. A future meeting date is set to discuss their findings.

In this scenario, the critical care manager had an identified QI system issue that needed to be addressed. In other cases, multiple unit issues may need to be investigated or the manager may be approached by an undergraduate or graduate level nurse interested in doing a capstone project who is looking for suggestions. How do you decide which project to tackle? Do you have the resources, time, institutional support, and expertise equal to the complexity of the project to ensure the project can be carried out, or is it doomed to fail? The purpose of this article is to examine a variety of factors that should be considered before embarking on a QI project to maximize the odds of success.

**Identifying System and Performance Projects Specific to Your Unit or Patient Population**

**There’s No Place Like Home**

First look at patient safety and preventable harm situations on your own unit or in your institution—is there anything that poses an immediate threat of actual or potential harm that needs to be urgently addressed? Has there been a sentinel event applicable to your critical care area? Do incident reports document any patterns or trends related to specific types of occurrences such as falls or infection rates? Are there any high-volume, high-risk population groups, procedures, or treatment options that consistently increase morbidity and length of stay for your unit?

Use your institutional experts, primarily the managers of the QI, risk management, and infection control departments. Hospitals are federally mandated to report clinical outcome statistics for a variety of measures, and many institutions voluntarily belong to registry systems that provide risk-adjusted benchmarks for tracking institutional clinical outcomes against other institutions. One such program is the American College of Surgeons Trauma Quality Improvement Program, which collects reliable data, identifies institutional characteristics associated with improved outcomes, and provides feedback to more than 200 participating trauma centers.

**Recreate It, Don’t Reinvent It**

Let the experts do the work for you. Professional organizations have the combined resources and expertise to review the most current evidence-based studies and best practices in order to develop standard-of-care guidelines and recommendations. The Centers for Medicare and Medicaid Services, National Committee for Quality Assurance, National Quality Forum, Agency for Healthcare Research and Quality, and the Institute for Healthcare Improvement each offer a variety of ready-to-use guidelines, outcome measures, references, data collection tools, and data-reporting tools for QI.

The American Association of Critical-Care Nurses offers free online access to 2 clinical tool kits to help simplify the sharing and implementation of new practices. Each kit provides evidence-based strategies, resources, guidelines for implementation, examples of best practices, and change implementation tools. The available toolkits are Strategies for Managing Alarm Fatigue, which addresses the desensitization of nurses to noticing and responding to clinical alarms, and Implementing the ABCDE Bundle at the Bedside, to help prevent the unintended consequences of critical illness such as delirium, prolonged ventilation, and excessive muscular deterioration.

The June 2013 issue of *Critical Care Nurse* was devoted to patient safety strategies and initiatives to prevent harm. Grif Alspach discussed the work of a project team commissioned by the Agency for Healthcare Research and Quality that came together with an international group...
of experts and stakeholders to analyze, critique, and appraise the evidence for various patient safety strategies. The expert panel recommended 10 patient safety practices for immediate adoption by health care professionals and an additional 12 practices that were encouraged for adoption (Tables 1 and 2). Dr Alspach expanded on the tables in her editorial, providing information about the frequency and severity of each of the strategies, the strength of the evidence, cost estimates, and the degree of difficulty to implement.

**Table 1 Ten patient safety strategies strongly recommended for immediate adoption**

1. Preoperative checklists and anesthesia checklists to prevent operative and postoperative events
2. Bundles that include checklists to prevent central catheter–associated bloodstream infections
3. Interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols
4. Bundles to prevent ventilator-associated pneumonia that include head-of-bed elevation, sedation vacations, oral care using chlorhexidine, and subglottic endotracheal suctioning
5. Hand hygiene
6. The do-not-use list for hazardous abbreviations
7. Multicomponent interventions to reduce pressure ulcers
8. Use of real-time ultrasonography for central catheter placement
9. Barrier precautions to prevent health care–associated infections
10. Interventions to improve prophylaxis for venous thromboembolisms

**Table 2 Twelve patient safety strategies encouraged for adoption**

1. Multicomponent interventions to reduce falls
2. Use of clinical pharmacists to reduce adverse drug events
3. Documentation of patients’ preferences for life-sustaining treatment
4. Obtaining informed consent to improve patients’ understanding of the potential risks of procedures
5. Team training
6. Computerized provider order entry
7. Medication reconciliation
8. Practices to reduce radiation exposure from fluoroscopy and computed tomography
9. The use of surgical outcome measurements and report cards, such as those from the American College of Surgeons National Surgical Quality Improvement Program
10. Rapid-response systems
11. Use of complementary methods for detecting adverse events or medical errors to monitor for patient safety problems
12. Use of simulation exercises in patient safety efforts

Steal Shamelessly

Too often we focus on what is not working and we forget to look at what is being done well. If a critical care unit in your institution or another institution is thriving, study that unit! What are the staff in that unit doing differently that can be identified, quantified, duplicated, and implemented on your own unit? Talk to the unit managers, staff, physicians, and other health care professionals to get their input on why that unit is successful. Try to do a 24-hour walk-through of their day from both a patient/family perspective and from a staff perspective. Make a flow chart of your unit and the successful unit and compare them for similarities and differences. Depending on the practice issue, you may want to include tangible factors such as staffing, staff mix, availability of advance practice nurses as mentors, number of beds, mean severity scores, population served, mean age, most common diagnoses, interaction with resident physicians, use of hospitalists or intensivists, technology related to available equipment and supplies, technology for medical record documentation, use of evidence-based practices such as checklists and bundles, common patient safety concerns, and QI initiatives. Intangible factors are more difficult to measure but may include communication techniques with peers, patients, and families; expectations for staff professionalism; the mix of novice to expert care providers relative to knowledge and expertise; interaction with other systems of care; and educational opportunities for staff and patients. You will not be able to replicate everything, but “shamelessly steal” any ideas, techniques, procedures or checklists that they are willing to share.

Be Brutally Honest About Available Time and Resources

Transparency in reporting of outcomes, reimbursement based on outcomes, continued accreditation, and employment dependent upon outcomes is essential—no
Replicate and learn from others’ proven success strategies.

matter where you work or what your professional role is in health care, it is all about measurable outcomes. Unfortunately, with a leaner work force and the push to do more with less, trying to incorporate yet another task into everyday practice may be met with resistance. An overly ambitious project that puts additional time constraints on employees and is perceived as not being of value will quickly wither and die. Projects should include the use of nurse, physician, or administrative champions as invaluable resources who can facilitate peer education and encourage implementation of QI projects through close personal connections to their colleagues.

Farner et al described champions as “advocates of new ideas or projects for which they feel personal ownership” and they reported an “enhanced sense of collaboration and coordination of care” among nursing staff members when nurse champions were used as leaders.

Goldmann discussed 10 tips for incorporating QI activities into real work instead of parallel processes separate from the average work day. He suggests designing easy-to-use data collection forms or checklists that actually improve ease and reliability of charting both for QI and for routine care. The use of standardized order sets or drug utilization reviews are 2 examples of how QI data collection can be incorporated into regular workday activities.

We disagree with Goldmann’s opinion that projects should be of sufficient magnitude and impact to “make a major difference” and “rise to a level . . . designed to substantially improve key processes of care.” He discourages “limited though useful QI initiatives” that are small scale. Large projects may be too intimidating or overwhelming for novice participants or those with limited resources, increasing the odds the project will never get started or will meet with significant challenges and possible failure that will discourage future endeavors. QI needs to be realistic and achievable. It is not research—the intent is not to push the envelope, generate new knowledge, and get published but rather to use existing evidence and tools to change practices to prevent potential or actual harm. Start with “low-hanging fruit”—small projects that are well studied in the literature, have free ready-to-use resources, and can be easily initiated with a minimum budget and little disruption of work flow, but can result in significant outcomes specific to that unit. For example, hand hygiene remains 1 of the top 10 patient safety issues that have a seemingly simple answer but no real success with ongoing sustained compliance.

Conclusion

At the scheduled QI follow-up meeting, your team member summarizes her findings but is especially excited about studies she reviewed that used the relationship-based nursing care delivery model. One study prospectively implemented a project of providing safe, personalized care to maternity unit patients with measurable outcomes for patient satisfaction, patient safety, and improvements in the perception of nursing teamwork. A second retrospective study in a small rural hospital evaluated the impact of the relationship-based care model before and after implementation by using Press Ganey scores to measure patient satisfaction, length of stay, and readmission rates.

She had also located an online summary of a nursing doctorate project based on the relationship-care model that examined the impact of patient- and family-centered interventions on Press Ganey patient satisfaction scores. It provided a complete overview of the project, including the interventions used: a method for inviting patients and families to participate in the care plan, providing a bedside notepad for questions, and scripting for the health care team to ask patients and families “What do you want to see happen today?” The group was especially excited about the minimal cost and time commitment to implement and the focus on interpersonal communication skills and family-centered care. Input from the nursing staff indicated support for further exploration and possible replication of the interventions described. An experienced nurse with a successful history of championing new initiatives volunteered to contact the author for further discussion and possible mentoring. The meeting concludes with your promise to arrange an in-service training session for staff with the manager of the QI department to discuss various methods for conducting QI projects that are used by your institution.

Part 3 of this series, “Where and How To Get Started—the DIY (Do It Yourself) Guide for QI Projects” will provide an overview of the most commonly used QI methods and suggestions for how to plan, implement, evaluate, and report QI projects. The final article will discuss use of the Standards for Quality Improvement
Reporting Excellence (SQUIRE) Guidelines for publishing QI studies. CCN

Financial Disclosures
None reported.

Letters
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References

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1. Some items to consider when choosing a quality improvement project for your department include all except which of the following?
   a. Availability of resources to manage the project
   b. Approval from the institutional review board to conduct the project
   c. Institutional support for the project
   d. Availability of expertise to complete the project

2. Which of the following items should be considered when choosing a project?
   a. Identifying systems and performance projects specific to your unit
   b. Identifying systems and performance projects specific to your patient population
   c. Considering patient safety and preventable harm situations
   d. All of the above

3. Which of the following is not a recommendation from the authors for identifying system and performance projects specific to your unit and patient population?
   a. Use of expert resources within your own institution
   b. Reinvent projects based on creating new knowledge
   c. Recreate work that has already been done
   d. Be honest about available time and resources

4. Department-based quality projects should include which members of the care team?
   a. Nurses, physicians, facility senior leadership
   b. Nurses and patients only
   c. Nurses, physicians, and/or administrative champions
   d. None of the above

5. Which of the following statements related to quality improvement is not true?
   a. Quality improvement is not research.
   b. Quality improvement generates new knowledge.
   c. Quality improvement is intended use existing evidence and tools to change practice and prevent actual or potential harm.
   d. Quality improvement projects need to be realistic and achievable.

6. Which of the following are tips for choosing a quality improvement project?
   a. Areas of opportunity for implementing evidence into practice
   b. Application of tools that will change practice and improve patient safety
   c. Start with “low-hanging fruit” determined from evaluation of evidence-based practice
   d. All of the above

7. Which of the following safety strategies have been endorsed by the American Association of Critical-Care Nurses since 2013?
   a. Checklists and bundles
   b. Hand hygiene and barrier precautions
   c. Interventions to reduce health care–associated infections
   d. All of the above

8. Which of the following is a recommended way to identify successful quality improvement techniques from another unit that could be incorporated into your own unit’s practice?
   a. Share relevant quality improvement articles published in the nursing literature
   b. Make a flow chart of your unit and the successful unit to compare similarities and differences
   c. Use standardized checklists for specific outcome measures you are trying to improve that have been successful on other units
   d. All of the above

9. Methods described in the case study include which of the following?
   a. A literature search that included a retrospective study
   b. A literature search that included a relationship to a care delivery model
   c. Both a and b
   d. None of the above

10. Which of the following safety behaviors was listed as number one of the top 10 patient safety issues?
    a. Preoperative checklists and anesthesia checklists to prevent operative and postoperative events
    b. Interventions to improve prophylaxis for venous thromboembolisms
    c. Barrier precautions to prevent health care–associated infections
    d. Hand hygiene practices