Lehigh Valley Health Network

LVHN Scholarly Works

Patient Care Services / Nursing

Stop the Chaos! One Patient at a Time, Please

Megan Snyder BSN, RN, BC Lehigh Valley Health Network, Megan.Snyder@lvhn.org

Follow this and additional works at: https://scholarlyworks.lvhn.org/patient-care-services-nursing

Part of the Emergency Medicine Commons, and the Nursing Commons

Let us know how access to this document benefits you

Published In/Presented At

Snyder, M. (2012, September 19-20). Stop the chaos! one patient at a time, please. Poster presented at: The Pennsylvania Organization of Nurse Leaders 2012 Annual Leadership Symposium, State College, PA. Poster presented at: The Academy of Medical-Surgical Nurses 21st Annual convention, Salt Lake City, UT. (October 4-7, 2012)

Poster presented at: The Magnet Champion Conference at Lehigh Valley Health Network, Allentown, PA. (June 19, 2013)

Smith, J. (2014, February 5-7). Poster presented at: The ANA 7th Annual Nursing Quality Conference, Phoenix, AZ.

This Poster is brought to you for free and open access by LVHN Scholarly Works. It has been accepted for inclusion in LVHN Scholarly Works by an authorized administrator. For more information, please contact LibraryServices@lvhn.org.

Stop the Chaos! One Patient at a Time, Please

Lehigh Valley Health Network, Allentown, Pennsylvania



Pre-Project Current State

- PULL was more like PUSH
 - PULL time from when assigned bed becomes clean to time patient occupies the bed
 - PUSH was movement of patient at time of convenience
- Long "tail" of PULL between 60 and > than 90 minutes the tail drove patient and employee dissatisfaction
- Med-Surg units experienced influx of admissions from ED
 - "Bolus" or "batching" of patients
 - Regardless of unit situation
- Driving forces Need to move patients out of ED
 - Accommodate more patients
 - Improve patient satisfaction



PROJECT GOAL: Patient transport from documented time of admission in the Emergency Department (ED) through transport to assigned medical-surgical bed occurs within 50 minutes, inclusive of standard, required handoff communication.

GEMBA

Japanese term for 'actual place;' the setting where work takes place

Gap Analysis

- Delays in bed assignments
- Delayed and closed loop communication handoffs
- Untimely transport requests
- Limited use by med-surg staff of electronic mechanism to prioritize bed assignments

Countermeasures

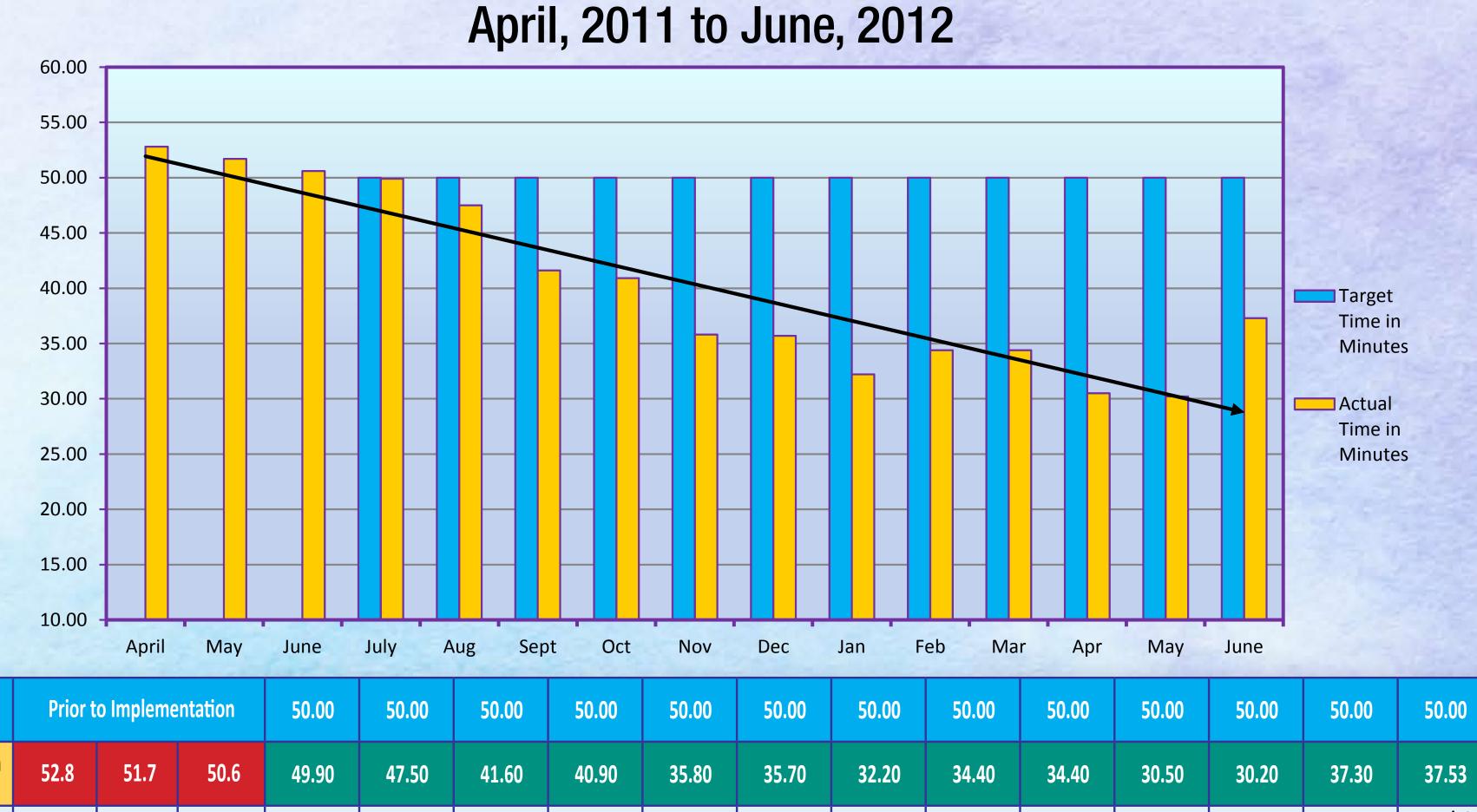
- Mandatory use of electronic mechanism to prioritize bed assignments
- Completion by ED nurse and availability of handoff report to receiving RN prior to transport
- Request for transport by receiving unit only after handoff report is secured

Sustaining the Effort

- Real-time quality metric board visible to all stakeholders
- Ongoing analysis of transport times from ED to med-surg unit

Outcomes

PULL TIME: Pilot unit April. 2011 to June. 2012



References:

- 1. Shook, J. Managing to learn: using the A3 management process to solve problems, gain agreement, mentor, and lead. Cambridge, MA. The Lean Enterprise Institute. 2008.
- 2. Eitel, D, Rudkin, S, Malvehy, A, Killeen, J, Pines, J. Improving service quality by understanding emergency department flow: A White Paper and Position Statement Prepared For the American Academy of Emergency Medicine. The Journal of Emergency Medicine, 38:1, 70-79.



A PASSION FOR BETTER MEDICINE.