

ED PIP: Solution Design Phase

Guides: Hypothetical Examples

The tools and guides presented in this toolkit are not mandatory in any given situation. The following examples provide a good illustration of how the items presented in this toolkit can work in practice

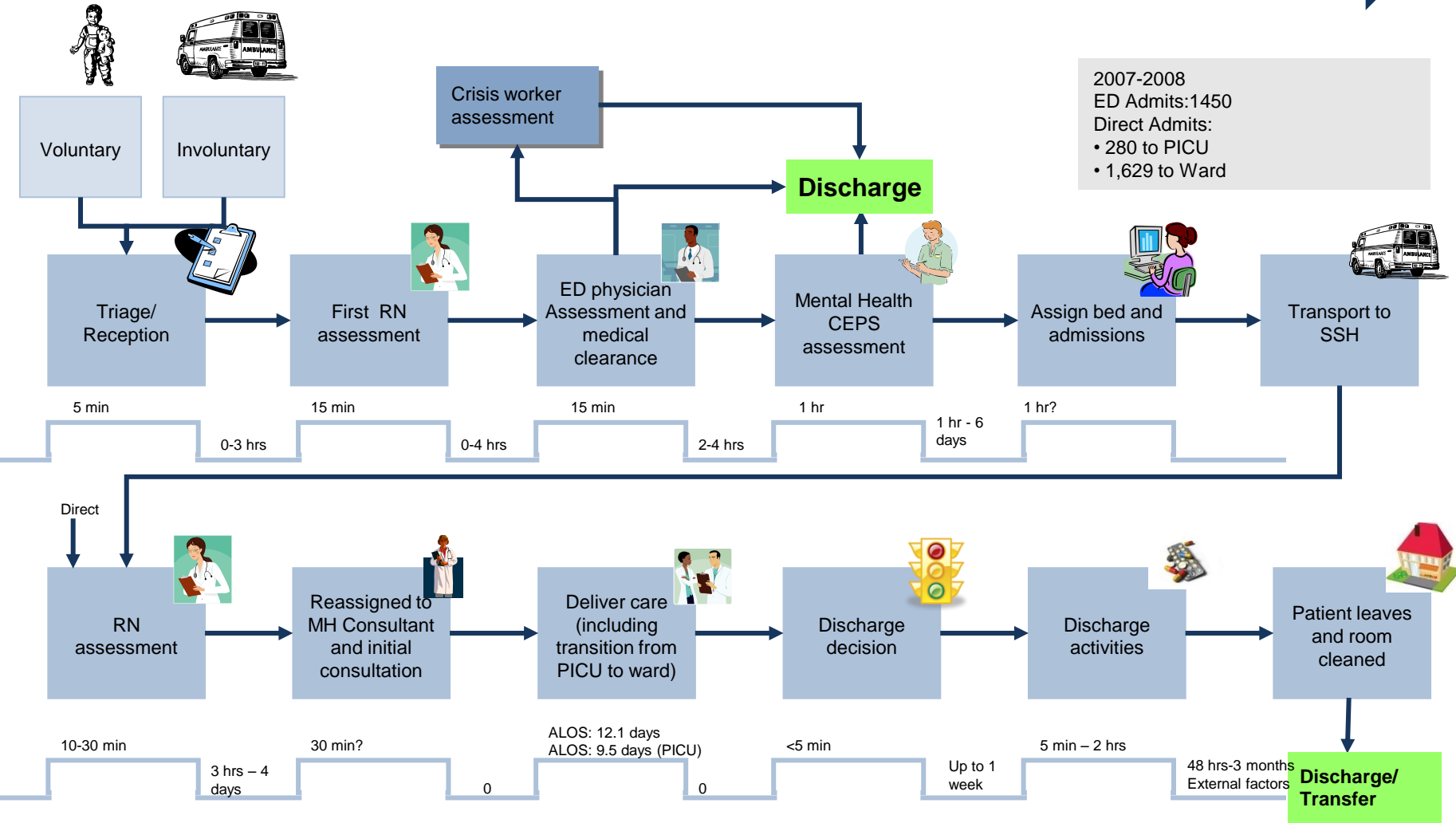
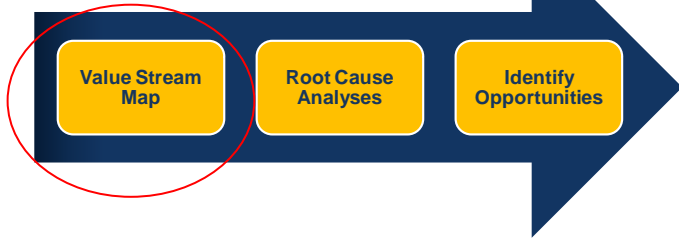
Consider patient flow example in the ED re: mental health processes...

**Value Stream
Map**

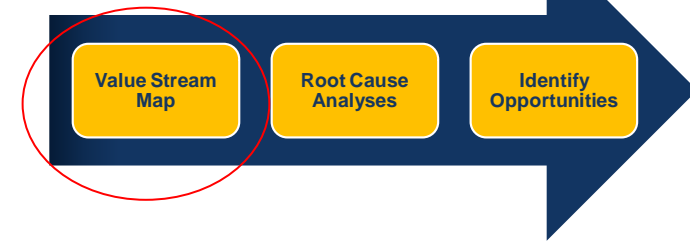
**Root Cause
Analyses**

**Identify
Opportunities**

As we consider the mental health processes related to ED patient flow, we start with the value stream map...



We need to observe the value stream and analyze...



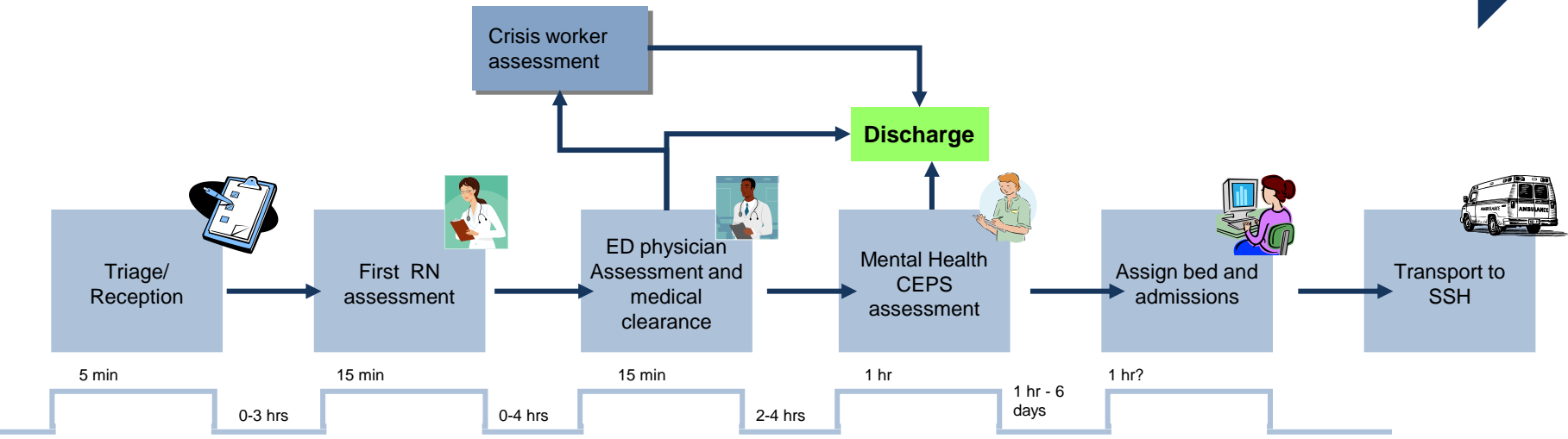
Observations

1. Total time from admission to transfer to SSH is highly variable.
 - At best, the process takes 4 hrs 35 minutes (max value add time = 2 hours 35 minutes)
 - At worst, the process takes 7 days (max value add = 2 hrs 35 minutes)
2. Waiting time between next steps contributes to much of this variability

Next steps

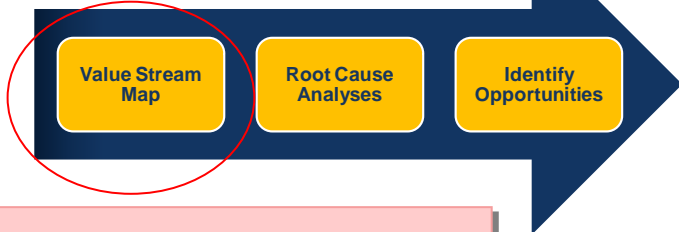
1. **Select which part of the VSM to focus on – where will we begin to eliminate a substantial amount of waste?**
2. **Determine the potential causes of the problem and which one(s) occur most frequently**
3. **Plan for improvement**

What problem are we going to focus on?



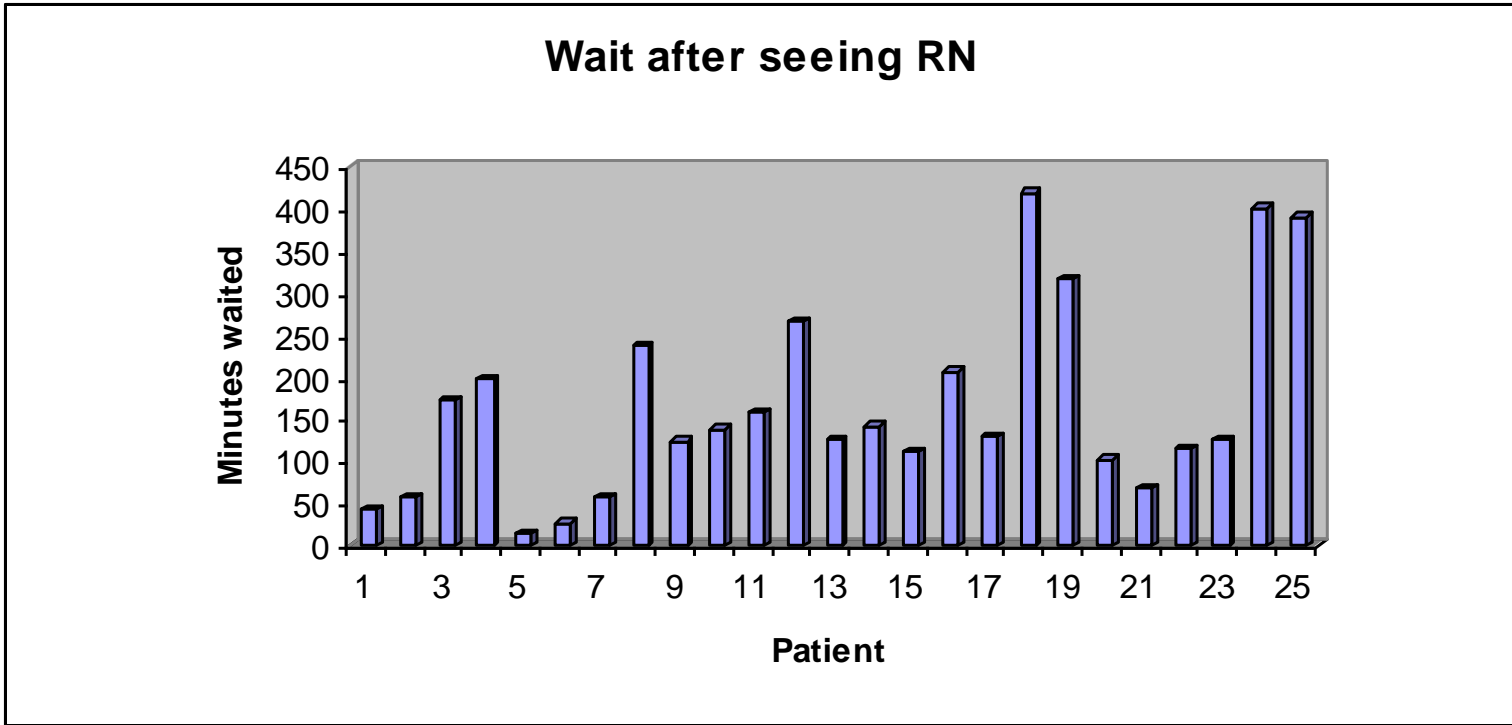
**Why must patients wait for the MD assessment?
How variable are the wait times? How long are patients waiting – 80% of the time?**

There is significant variability in how long patients wait after being assessed by the RN

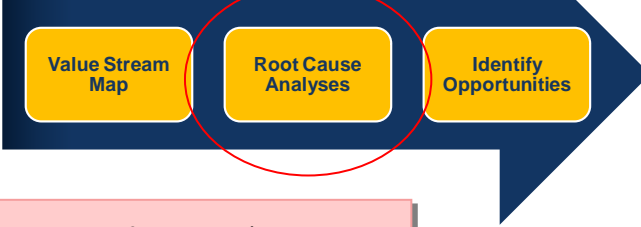


Average = 166 minutes Median = 129 minutes
Range = 13 to 420 minutes
60 % wait > 120 minutes 80% wait > 45 minutes

Sample of 25 patients seen in the ED during a 1 week period

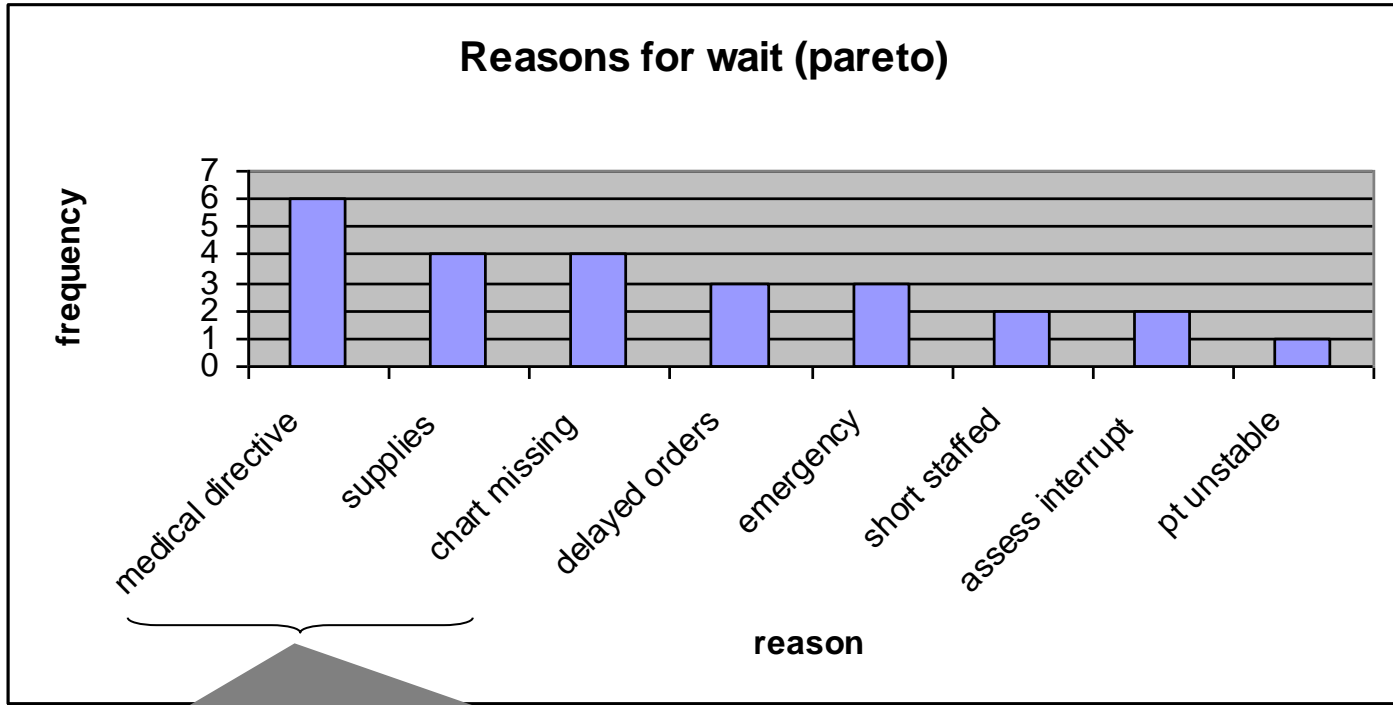


What are the “vital few” reasons for the delay?



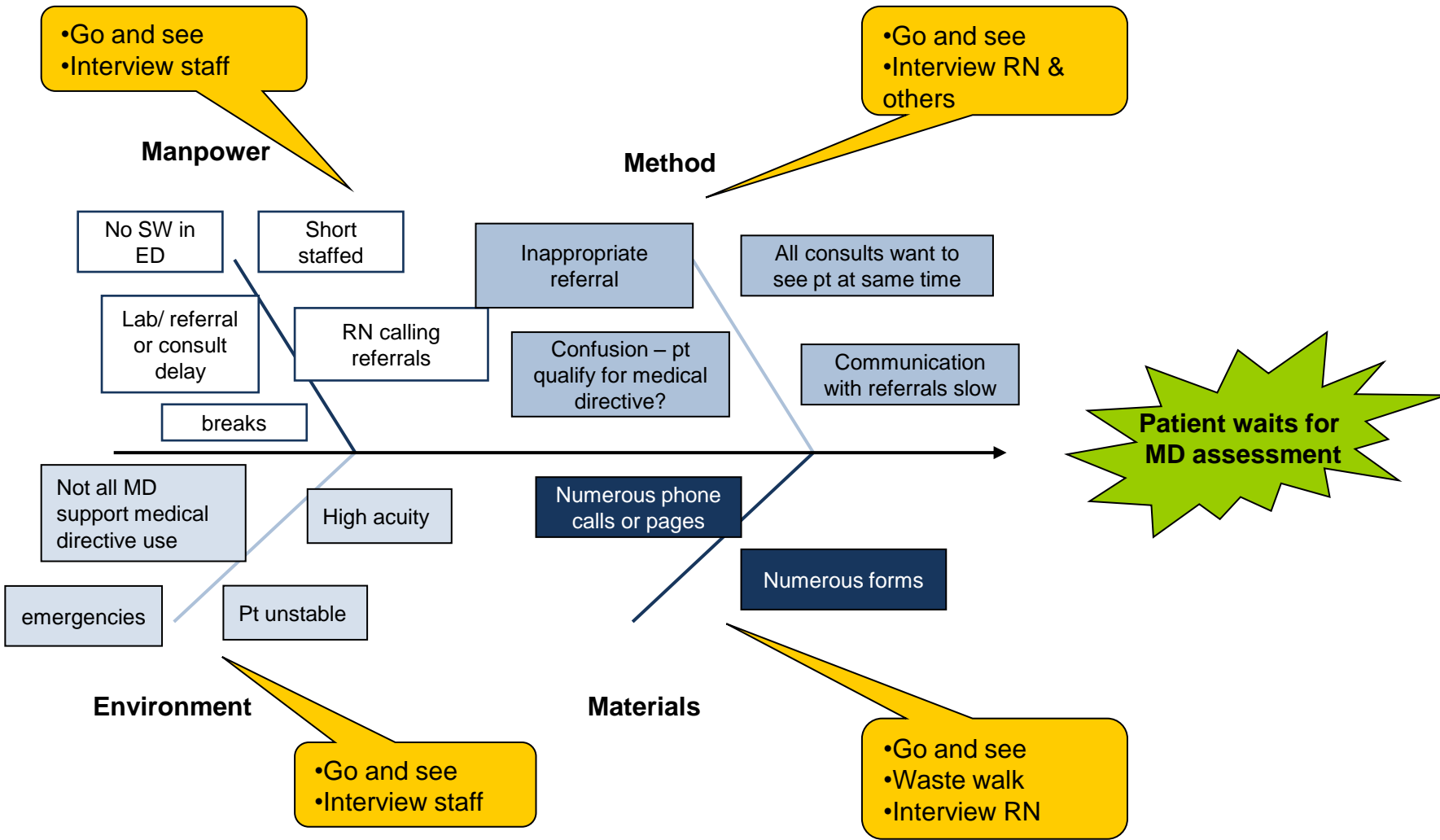
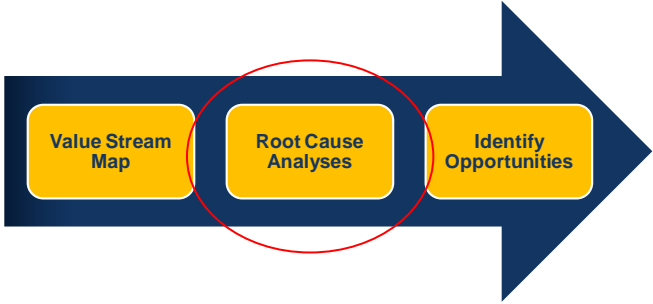
Medical directives not being followed/ executed, getting supplies and missing charts account for almost 50% of the delays

Sample of 25 patients seen in the ED during a 1 week period

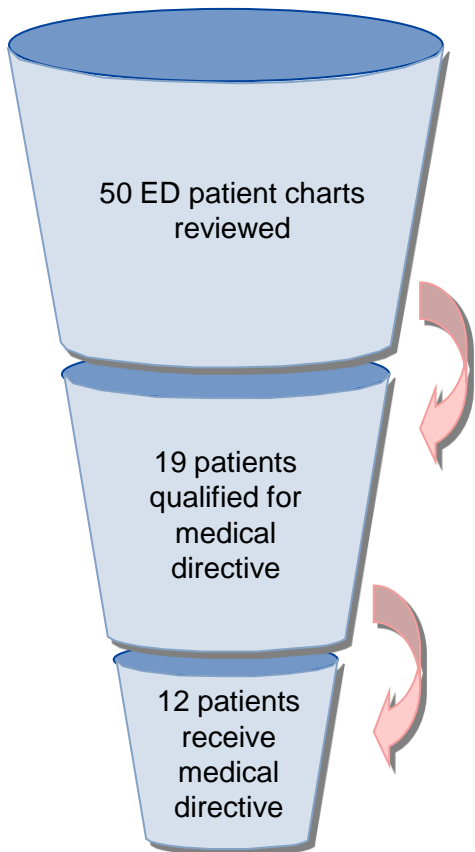
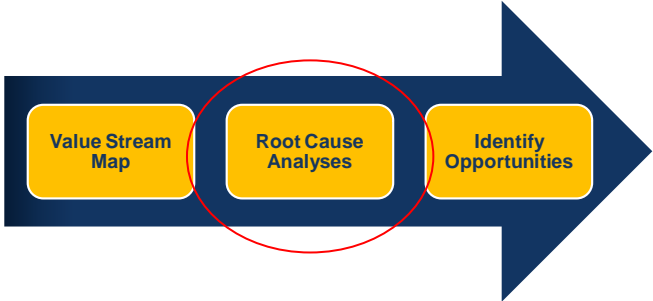


Learn more about these issues....

Why aren't medical directives being executed appropriately?



Sampling indicates that the existing medical directives are not being consistently applied



Observations

- Medical directives are not being applied consistently

Potential root causes

- Lack of clarity on when and how to apply
- Nurse comfort level
- RN distracted – delayed start to medical directive

Representative quotes

- “Some of the docs don’t like it when we use the medical directives”
- ED RN

- Concern over RN ‘authority’ to launch medical directive at point of care

- Confusion about professional practice (scope) and delegated medical act
- Perceived physician preference

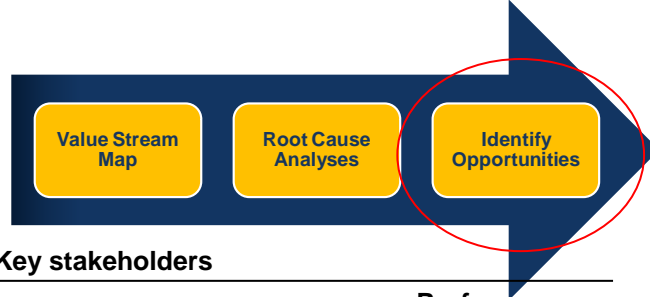
- “...we feel it [applying medical directive] speeds up the visit by 1 to 1 ½ hours”
- ED RN

- General agreement that medical directives are valuable in providing timely care to patients

What might we do to fix these problems?

Medical directive opportunities

Potential solutions generated by observations and team input. A representative group of stakeholders should be convened to generate solutions and PDSA



Area	Opportunity	Possible solution	Patient benefit	Ease of implementation	Key stakeholders				
					Sr Admin	Physicians	Nurses	Prof. practice	Other
Medical Directive	1 Clarify patient eligibility	<ul style="list-style-type: none"> Standardized discharge process (24, 48 hours) 	●	● August		✓	✓	✓	
	2 Clarify professional practice and RHPA	<ul style="list-style-type: none"> Patient care coordinator <ul style="list-style-type: none"> To join MD rounds Act as central communications point 	●	● September	✓	✓	✓	✓	
	3 Streamline or Automate launch	<ul style="list-style-type: none"> Standardize baseline information form and reduce duplication with ER Pre-printed ad-missions order forms 	●	● October		✓	✓	✓	✓

- *Patients and staff benefit from clear eligibility criteria*
- *Standardized use of medical directives and streamlining of launch will require changes in physician behaviour*



● High
○ Low