



S. Harvey Price is editor of *For Your Advantage*. A health care industry strategist based in Boca Raton, Fla., Mr. Price has worked as an independent consultant since 1971. His clients are community hospitals, hospital systems and major corporations.

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TrendLeader Connections
406-586-8775
www.ForYourAdvantage.com

Pitfalls of the Quick Fix

By Jameson Rehm

Managers' experiences tend to lead them toward problem solving in a certain way: Manage the situation; keep the chaos from boiling over. The more experience they have weathering these problems, the better they think they understand the tricks that work to quickly fix them.

What they miss out on is the ability to learn from the problems they face in their work environment. Given adequate time to reflect, they would surely come up with a deeper understanding of the world in which they work, but the truth of the matter is that kind of time doesn't exist in their busy world. Their patients need care and their employees need their guidance and direction now.

So how does one provide management decisions that are not only timely, but also provide long-term solutions?

One way to break through a shortsighted view of a problem is by using *root cause analysis*. The version used here was developed by Toyota. Its use demonstrated in the next section provides a basis for not only quickly uncovering unknown causes, but also encourages an interpersonally safe discovery process.

The root cause is discovered in the same manner as an inquisitive three-year-old: "Why, why, why, why, why?" If answered correctly, these questions will provide the ability to understand the problem and point to a clear solution.

This analysis also provides an added dimension of efficiency if problem solving begins with a safe environment. This means shifting the focus from counterproductive personal attacks to focusing on the problem that colleagues work together to solve.

To start the analysis, summarize the problem into one sentence. This creates a simple basis to start asking "why." If possible, understand the problem from the patient's perspective. This avoids the pitfall of serving one's own needs over the patient's.

For example, let's say an anesthesiologist had trouble adequately ventilating a patient and needed to switch ventilator machines mid-case, causing a delay in the surgery and considerable turmoil to the operating room because all the procedures that day were pushed back.

This problem can be summarized into: *This patient was having difficulty being ventilated.*

The next step is to start asking why.

(Continued...)

Pitfalls of the Quick Fix (Continued...)

<i>WHY? The air pressure could not break through to the lungs.</i>	Now the manager asks why the air pressure could not break through.
<i>WHY? Because this type of ventilator did not have the necessary function for this patient.</i>	They could understand clinically why the patient was not properly ventilated, but they should turn their focus toward circumstances in the environment to find something they can improve.
<i>WHY? The scrub tech put the wrong machine in the room.</i>	They follow their investigation then to the scrub tech, and discover that they stocked the room as correctly as they knew how. The scrub tech advises that they are usually able to guess when the patient would need special ventilation, but missed it this time.
<i>WHY? He read the pick list and saw "Ventilator," not "Ventilator w/ pressure option."</i>	The manager finds that the list the scrub tech reads is how they know what equipment to stock in the OR
<i>WHY? There is no option on the pick list to specify which ventilator is needed.</i>	They have arrived at their final answer.

My fifth and final answer points to a simple and obvious solution. The nurse manager takes a moment to amend the pick list options for the anesthesiologist to include which type of ventilator they need and it is clearly communicated to the scrub tech what to do when prepping for a procedure.

When faced with problems like this, I often think of something my father said to me: "There are no solutions, only problems with which we choose to live." I discovered the meaning of this since my use of root cause analysis.

These quick fixes often used in day-to-day work are providing short-term solutions to ever-changing and growing problems. The real problem isn't solved with a quick fix, it's merely that the quick fix pacifies a problem for a moment, and inevitably these moments pass. The good news is that by using root cause analysis, organizations can adapt along with the problems. As deeper solutions are continually applied to the endless stream of smaller problems, the fires administrators spend most of their professional lives putting out become surmountable.

If they treat problems as understandable parts of their work, then they begin seeing them as opportunities. Success, then, is no longer an accidental bi-product of working harder, as they have quickly and logically thought through each problem as an opportunity to improve.

Had the manager opted for the quick fix, she would not have known that this simple change would be the one thing needed to solve the problem. Without the disciplined root cause analysis, the manager would be spending thousands on a new ventilator and valuable time resolving interpersonal issues, rather than understanding the simple causes that remain hidden until one knows where to look.

Jameson Rehm is a healthcare management consultant who has taught problem solving to staff and administration in hospitals and hospices. He can be reached at rehm@kenagyassociates.com



Roles of NPs and PAs Growing Indistinguishable

They require two different types of training, however, in practical situations, nurse practitioners (NPs) and physician assistants (PAs) are increasingly being called upon to do similar work (particularly when the physician assistant has a master's degree). In many practices, the two are conducting physical examinations, diagnosing illness and prescribing drugs.

Primary differences are in education and in their relationships working with – or for – doctors. While the two take many of the same courses, NP training is focused on nursing, and PAs on the medical model. All of this is convenient for busy practices that need as much flexibility as possible in deploying their staff.

Despite their growing presents, each has its own limitations. For example, in Pennsylvania, nurse practitioners are supervised by doctors and available to respond to questions. However, PAs work directly for doctors and provide a limited scope of specified services. That's because their training differs meaningfully. To become an NP, one must have a bachelor's degree in nursing, then go on to get a master's in a subspecialty area. They also must get nationally-certified and state-licensed in their specialties, plus undergo periodic recertification-which includes the needs for continuing education credits. PAs may not end up with a bachelor's degree, much less a masters, though such programs are available.

Nurse practitioners can diagnose and treat illness; they can do medical histories and a physical examination. They can order diagnostic tests; prescribe medication and

certain other treatments. They can provide prenatal care; they can provide well-child care. They can educate patients who are seen in the primary care arena.

An increasing number of nurse practitioners are being hired into hospital settings where they may provide care within an intensive care unit and other settings. They work in hospitals, community clinics and health centers, in nursing homes and physician offices. They may work as school nurses. In almost any kind of health care setting, you'll find nurse practitioners.

Though they enjoy much independence, nurse practitioners in Pennsylvania must have some physician supervision, not necessarily on-site. For example, at the nurse practitioner-manned MinuteClinics in CVS drug stores, there is a physician on call to answer questions or suggest treatments. Those doctors also review the nurse practitioners' charts and provide feedback.

Physician assistants, on the other hand, work directly for and at the discretion of a doctor. The two sign a "delegation agreement," which outlines what work the PA can do.

A PA could potentially do everything a physician does, but usually the PAs are delegated a set of medical privileges that are basic to start with. If they work with specific physicians long enough, and if the physicians become comfortable with their work, they may add additional duties. Those duties might include prescribing narcotics and serving as first assistant in a surgery.

The differences between the NP and the PA are more and more indistinguishable.

About



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Nurses Study Staffing Ratios and Patient Safety

A study of the potential impact of state mandated nurse-to-patient staffing ratios in California hospitals revealed little impact on patient outcomes in two critical areas of patient care.

The findings were published in the March 2008 issue of *Policy, Politics & Nursing Practice*, a peer-reviewed journal that explores the multiple relationships between nursing and health policy. However, the study's researchers caution the results are far from conclusive in scientifically determining the required number of staff to provide quality care.

"Mandated alterations in the volume of direct-care staff alone have not resulted in expected reductions in the incidence of patient falls or the prevalence of pressure ulcers. Instead, we have found there are many variables we do not yet fully understand."

The findings are significant on a national level in that California serves as a bellwether in being the first state to enact legislation in 1999 mandating licensed nurse-to-patient ratios in acute-care hospitals. Ratios were phased in gradually based on the type and intensity of care. For instance, hospital medical and surgical units now have a ratio of one nurse to five patients; in 2004, the ratio stood at one to six. The study of pre- and post-regulation outcomes was conducted by the California Nursing Outcomes Coalition (CalNOC).

CalNOC's latest study bolsters its 2005 preliminary report on staffing and patient care quality in medical, surgical and definitive-observation units (step-down and telemetry units) from the pre-ratio period through the early implementation period. Then, as now, no statistically significant change was seen in the patient safety and quality (falls and pressure ulcer) outcomes monitored.

As anticipated, the study found significant increases in hours of care provided by registered nurses coinciding with decreases in the number of patients per RN. Accordingly, the skill mix data reflected an overall reduction in the use of licensed vocational nurses/licensed practical nurses on both medical-surgical units and step-down units. There also was a decline in the use of unlicensed nursing care staff.

While these staffing changes appeared to produce no statistically significant changes in the numbers of falls or the prevalence of pressure ulcers in the period from 2002 to 2006, several trends emerged that the CalNOC researchers expect to follow over time. Among them:

- On medical-surgical units, a larger percentage of contracted, temporary staff was associated with fewer

injury falls, but also with more hospital-acquired pressure ulcers.

- On medical-surgical units, there appeared to be an association between falls and hospital size, with smaller hospitals showing a decrease in falls while larger hospitals showed an increase.
- A general decrease was seen in the percentage of patients with community-acquired and/or hospital-acquired pressure ulcers from 2002 to 2006. On step-down units, the number of ulcers increased between 2002 and 2004 with a slight decrease in 2006. But the percentage of patients on step-down units with more severe pressure ulcers increased over the total time period.

Even as hospitals were increasing licensed staff to meet California's requirements, several state and national organizations were targeting falls and pressure ulcers as major elements of patient safety initiatives. These and many other unaccounted for variables and external factors make it difficult to accurately and independently measure the impact of staffing levels. Also, as the researchers point out, the study is based on data from CalNOC member hospitals, and it is not known how similar data from other hospitals might differ.

These findings must be considered preliminary at this time, providing an initial assessment while contributing to the growing understanding of the impact of mandates on hospital operations and patient outcomes.

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