

Solving Education Dilemmas Using Quality Improvement

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Disclosures

- The speaker(s) do not have any financial relationships to disclose.

To receive credit for today's BCH Academy
Session:

Text 3844 → 617-648-7950

Objectives

Discuss

Discuss several common educational dilemmas

Describe

Describe one basic approach to 5 Whys and Fishbone tools

Apply

Apply the 5 Why and Fishbone diagram process to an educational dilemma case

Educational dilemmas

Unexpected negative situations that poses question or concern for the teacher or group of teachers

Predicated on fact that the educators are well-intentioned and aspire to do well and connect with their students

Educational dilemmas

Before the event

- How do I get the leadership to care about the topic?
- I am out of my teaching depth here!!
- I can't do this alone!

During the event

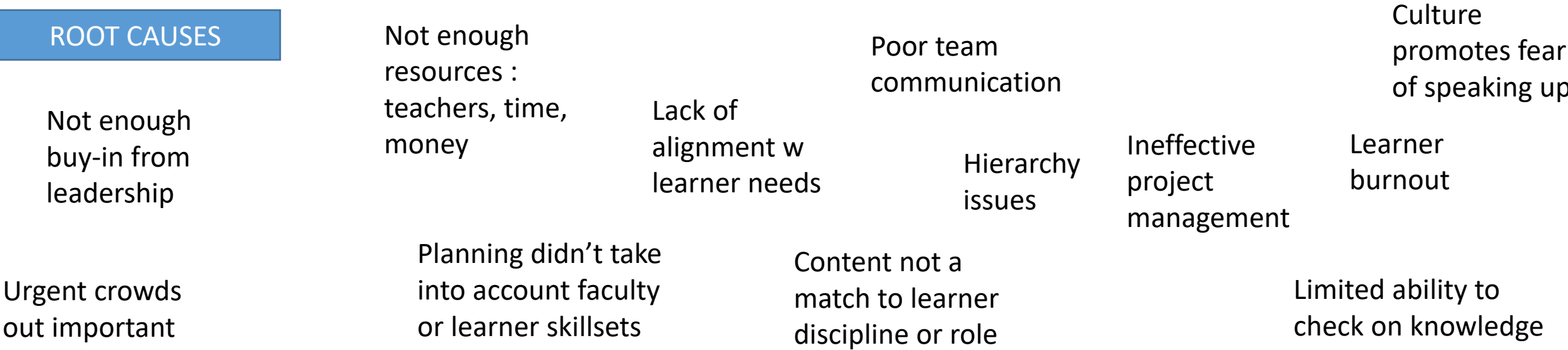
- Everyone seems confused!
- No one seems interested! Its like crickets in class.
- Learners today just aren't curious...no one came
- I can't get through all the material in time.

After the event

- No responses on the evaluation survey.
- They are asking me to teach it again next year. What should I do?
- What was the educational yield of the session?

WHAT WE SEE/FEEL

ROOT CAUSES



How do we solve dilemmas

We know we should...

- Articulate better to get buy in up front from leadership
- Plan better to make sure you have the right people engaged
- Execute better to make sure you have enough resources to get to the finish line

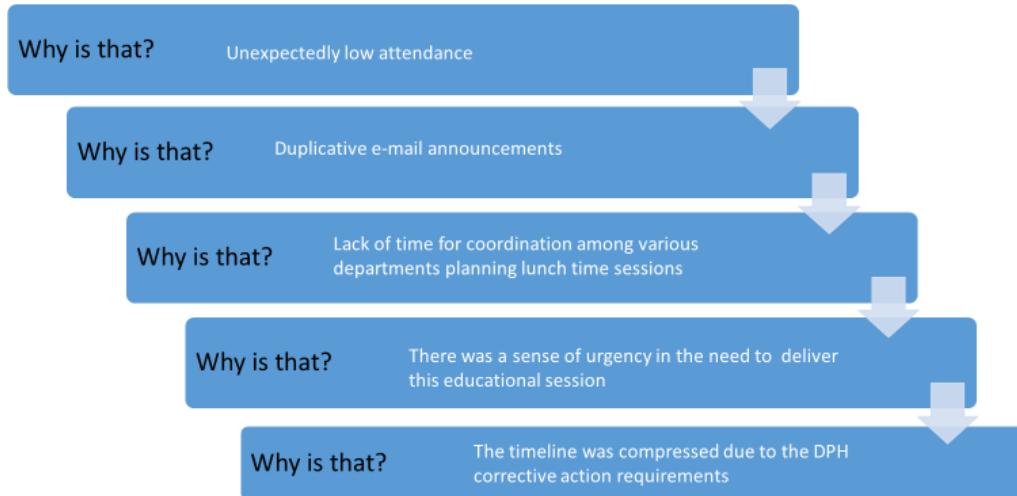
But....what *exactly* do I need to do better?

- Get specific
- Make fewer assumptions
- Target solutions to exact problems seen

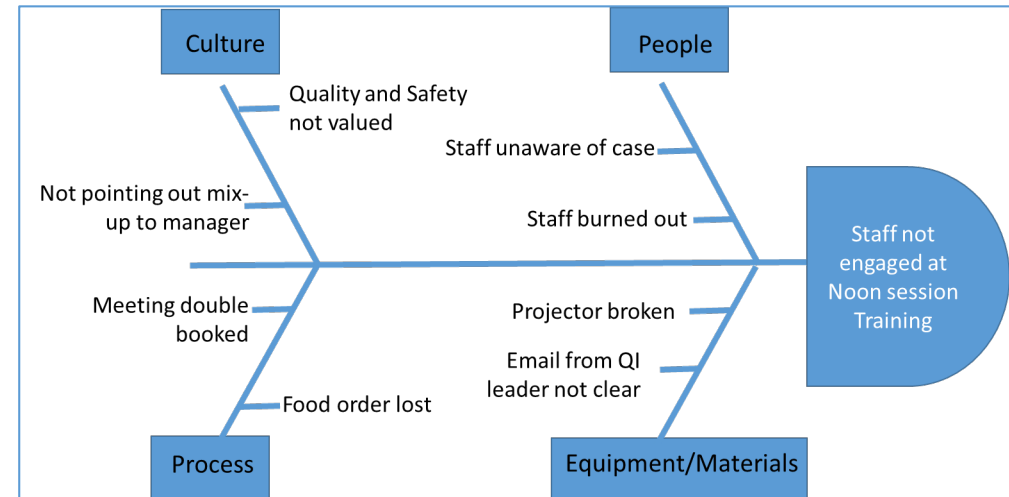
Two tools that may help us target solutions

5 whys

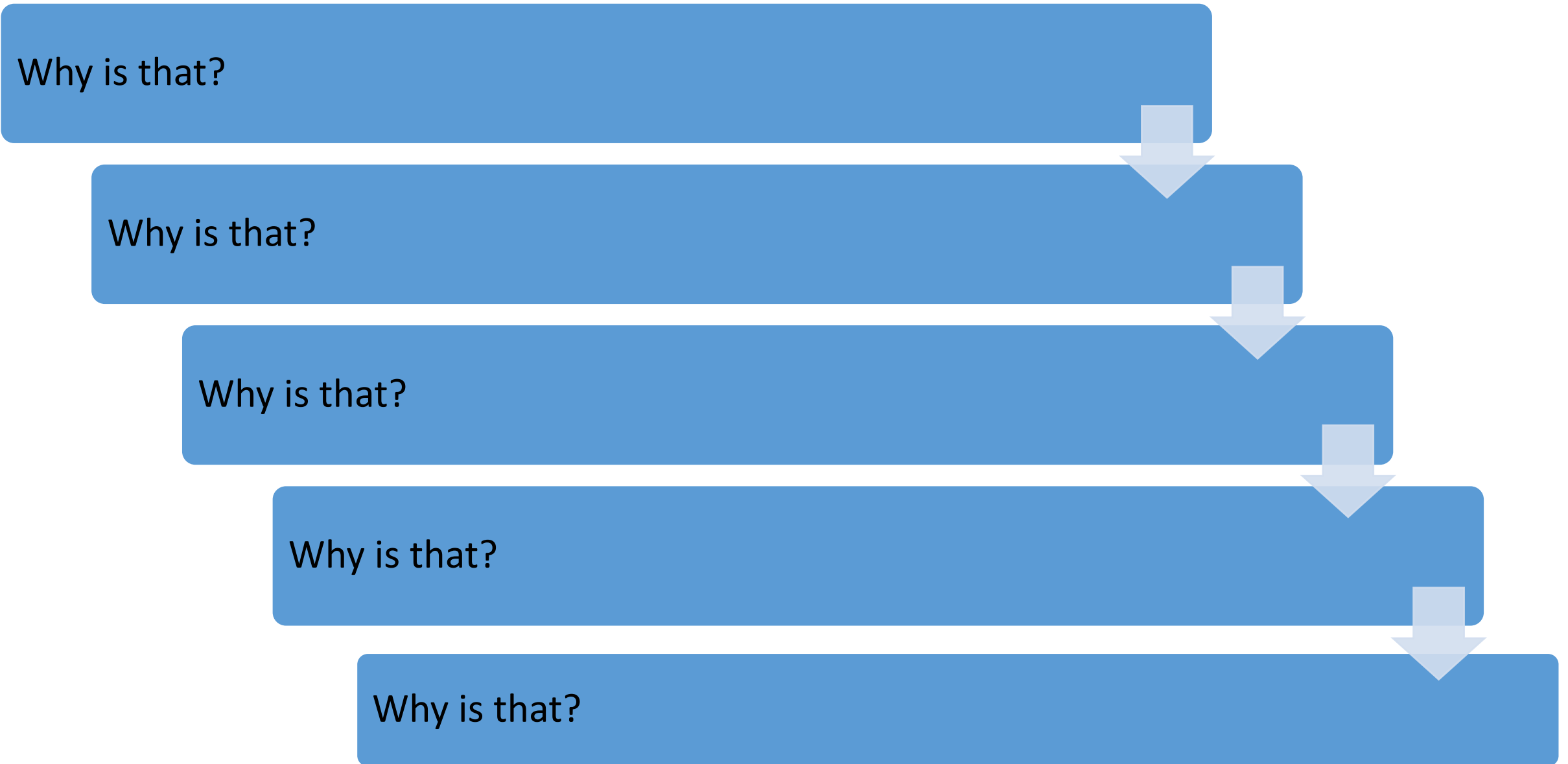
5 Whys - What happened? *Staff not engaged at noon session*



Fishbone diagram



5 Whys - What happened?



5 Whys - What happened? Titanic Sank

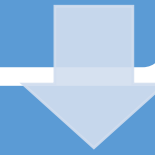
Why is that? Water filled the hull



Why is that? Opening in the hull



Why is that? Steel plates on the hull bent




Why is that? Strength of the steel



Why is that? Focus on cost savings

5 Whys - What happened? Patient Received the wrong medication


Why is that? The clinician did not complete the patient identification



Why is that? The patient did not have a wrist band.



Why is that? The wrist band had been removed for a procedure and not replaced.

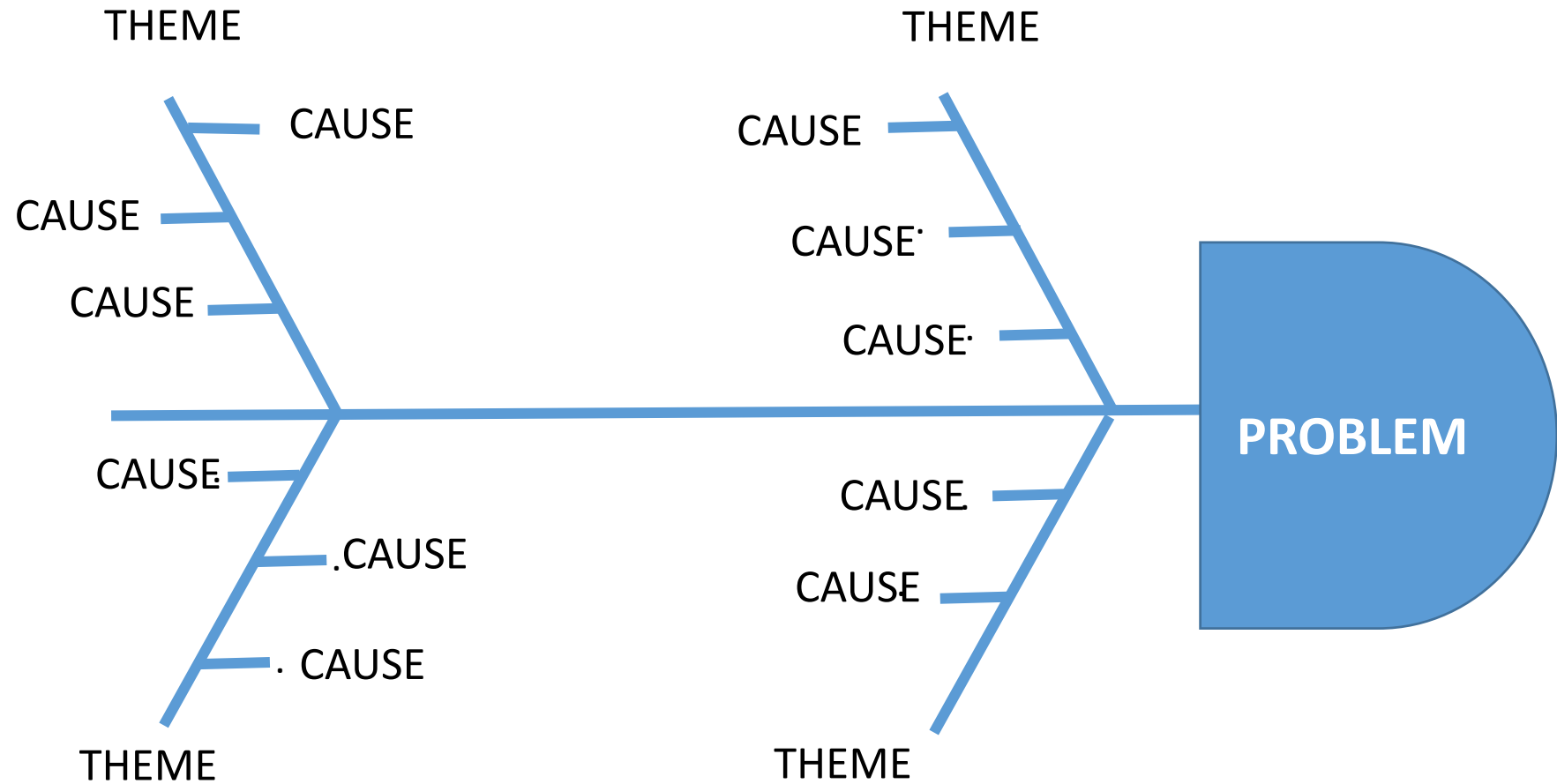


Why is that? The printer for wristbands was not working.



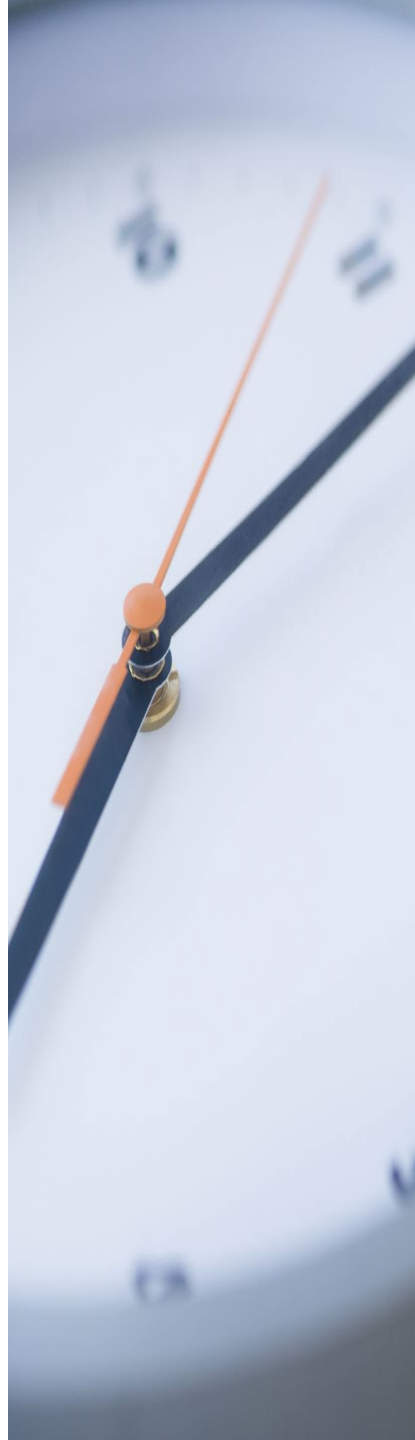
Why is that? The staff needed to support IT had been reduced and was overworked.

Fishbone

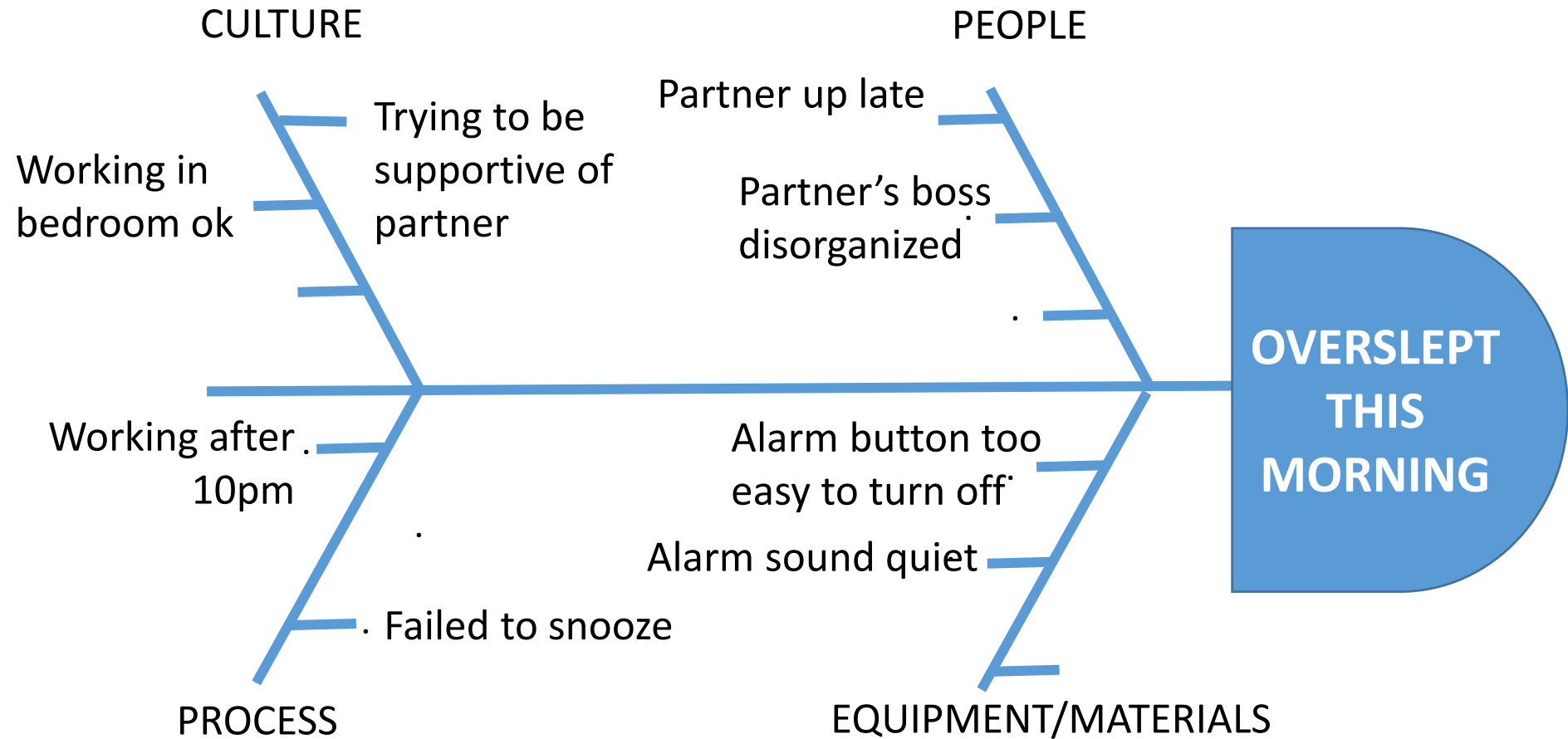


From Problem to Fishbone...

- I overslept this morning!
- My partner was up late working on an assignment that his boss gave him at the last minute yesterday.
- He was in the bedroom on his laptop until midnight, and I have been trying to be supportive as it is a new job.
- This morning I was so tired I slept through the quiet alarm. And when I did hear it I shut it off completely.



Fishbone diagram



AKA Ishikawa diagram

Fishbone technique

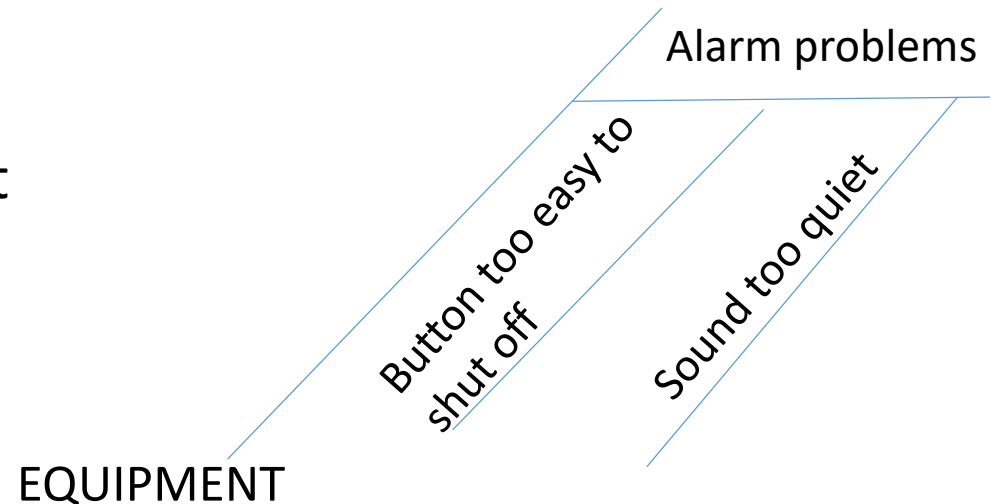
Brainstorm problems

- Make a list on the board
- Use 5 whys if needed to also get to the root cause of issues raised

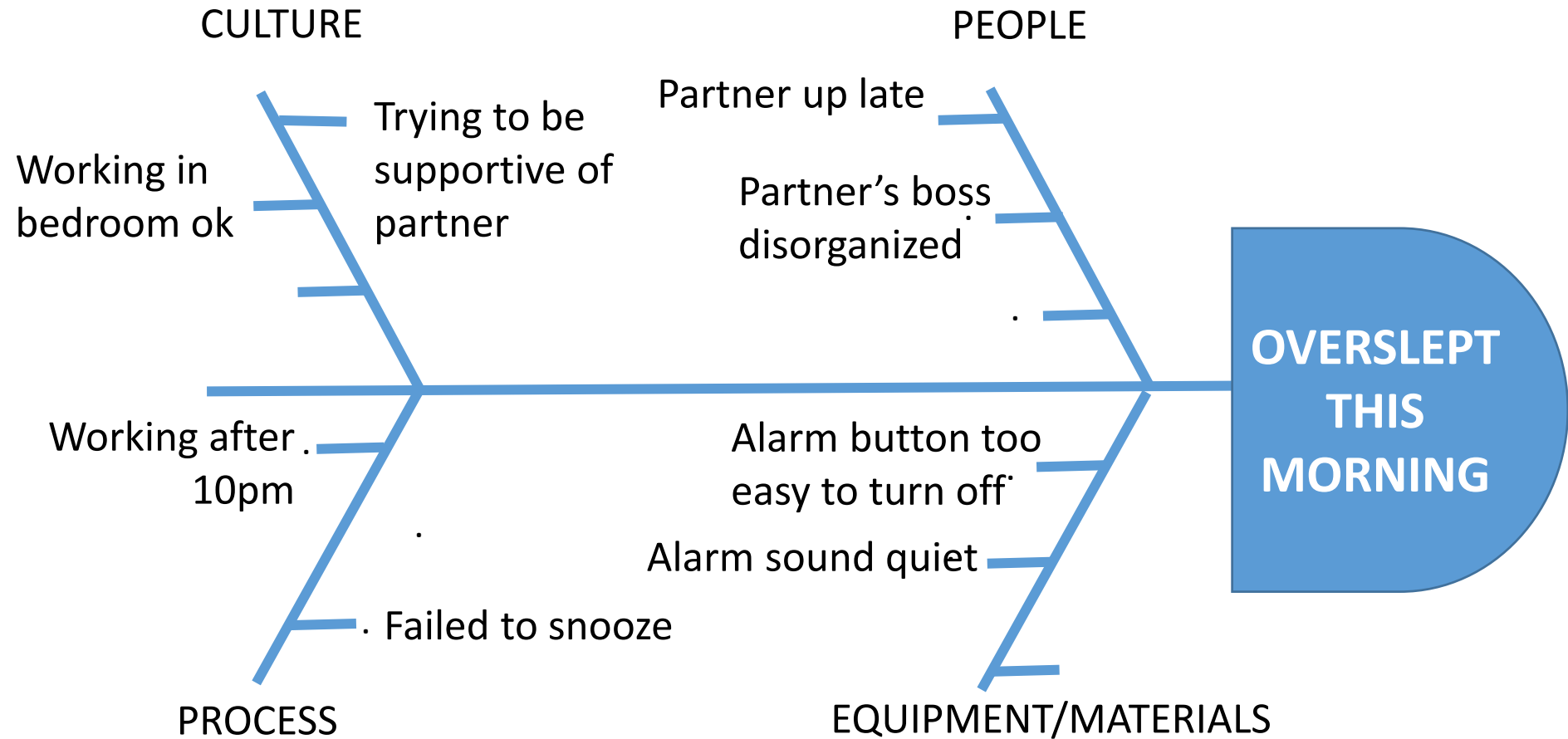
- So not “partner up late working” alone, but if keep pushing can get to the fact that his boss is also disorganized ;)

Map to fishbone

- Think about the theme it fits in and place it there
- Can also do sub-bones

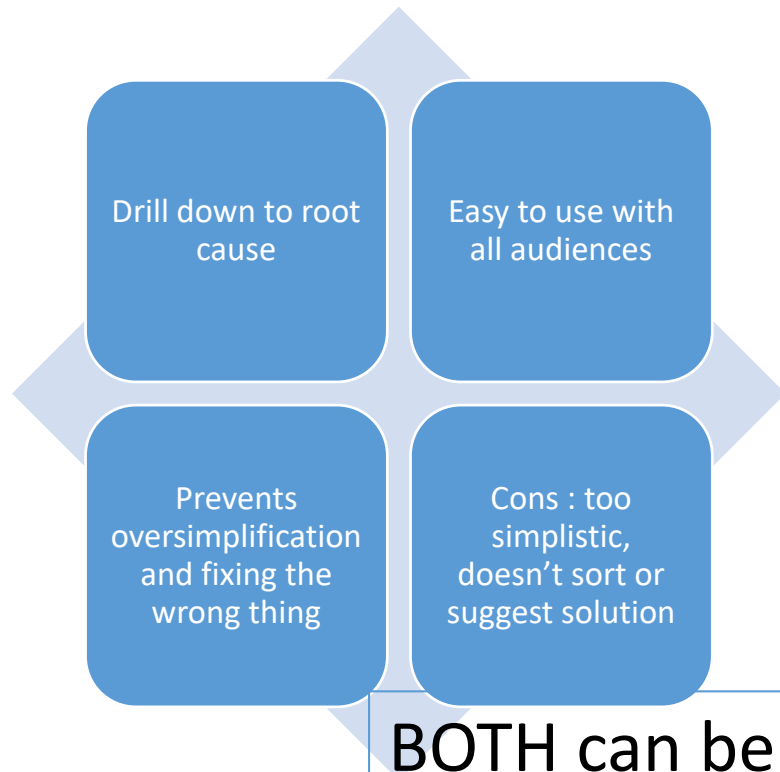


Fishbone



5 Whys and Fishbone : comparisons

5 whys tool



Fishbone diagrams

- Take root and other causes and sorts them in into themes
- Can help group like problems so you can solve more quickly
- Ideally solutions can attack multiple reasons at once
- Cons: too many root causes can be overwhelming, complex

BOTH can be done with an educational team to help understand a dilemma together and pick a solution

The case...

Protocol Education Gone Wrong at Be Well Hospital

The Huddle Implementation Gone Wrong at Be Well Hospital

- The Hospital's Clinical Protocol Committee has developed a new process to standardize clinical assessment at admission to the inpatient services.
- The intervention is part of a new effort to involve all members of the team early in the hospital stay.
- Due to new state regulations, this initiative requires a rapid implementation of two weeks.

The Huddle Implementation Gone Wrong at Be Well Hospital

- While not involved in the development of the new process, a clinical educator is charged with the educational roll-out of this initiative.
- After meeting with leadership, the educator schedules a lunchtime session for the team on Unit A.
- The Unit A manager sends an email to the healthcare professionals on the unit to attend a one hour session at lunch.

Lunchtime Session

- 20 people are expected attend.
- Two health professionals enter the conference room and immediately ask, “Why isn’t there lunch here for a lunchtime conference?”
 - The educator explains the lunch is late but has been reordered
- A Sr. health professional enters the room, sits in the back row and immediately questions, “Whose idea was this anyway?”
 - The educator explains it was organized by leadership
- One additional person joins the meeting and sits up front with their lunch bag and starts eating.
- The educator has trouble with the projector but eventually can start.

- No one asks questions during the session.
- The Sr. health professional uses their iPhone during the entire learning session.
- One of the four (total) attendees needs to leave the room to take care of an “urgent” situation. She doesn’t come back.
- At the formal Q & A section at the end, there are no questions, and everyone rushes out.
- One of the staff lets the educator know that likely no one else came because the session conflicted with another noontime HR meeting.
- Not one of the four attendees completes the evaluation at the end of the session.

Lunchtime Session Continues...

Follow-up

- You learn about what happened on Unit A and are charged with understanding the root cause of the educational dilemma.
- You decide to meet with several people including:
 - The educator
 - The unit manager
 - The chair of the clinical leadership committee
 - A faculty member



The Educator

- It was terrible, not what I expected at all. It didn't seem like anyone knew what this new process was trying to solve or why they were asked to attend.
- I felt badly about the lunch, we tried to get it there on time but the kitchen was apparently catering a lot of pizza lunches that day.
- It is also so hard when people are distracted on their phones and don't seem to be paying any attention.
- I started a few minutes late to wait for more people so I didn't leave enough time at the end for learners to complete the evaluations.
- Ugh! The projector was also a real problem!

Manager of Unit A

- One thing I knew about is the two different lunch time talks that were scheduled that day one by the HR team and one by the educator. Both were at the same time in two different locations. No one mentioned the HR one to me until the day before our Protocol one. I didn't want to reschedule ours again. It's hard enough to find one date.
- Our staff has been working very hard and it has been challenging to engage them in implementing new processes.
- Honestly, I don't think that anyone appreciated the urgency of completing these sessions since no one knew about the requirement by the DPH to complete the education within a certain timeframe.

Chair of the Clinical Protocols Committee

- There needed to be a very quick turnaround following a new requirement from DPH. We knew that the timeline was aggressive, but we had no other options than to do this quickly. Coordination and planning has been challenging.
- We can't broadly share details about every new protocol so creating a sense of importance was a challenge.
- It has been harder getting our professionals to protocol related educational sessions as there have been a lot of these lately.

Faculty member

- I had no idea about why we were being asked to change our protocol– this was all news to me. I hadn't heard about the requirement either. Emails were not clear that this was so urgent
- It was frustrating that there was no lunch – this was really the only time I was going to have to grab a bite to eat as we have been so busy. As it is I was getting patient care emails the entire time. It is so overwhelming.
- I totally agree we must do assessments better– but honestly just once I'd like something to come off my list. All the administration does is add more work. Where's the 'NOT to-do list'?

Name this
problem!!

- What dilemma this educator is facing?
- Put it in the chat!



Breakout instructions

- We will be breaking you into groups of 6 for 15 min
- Each group will assign reporter/scribe based on the nearest birthday
- We have provided you with a tool to think through two things:
 - 1) Take one or two factors you saw or heard in the case and complete a 5 whys
 - 2) Brainstorm all the potential factors you heard that contributed to the lack of engagement of professionals in the educational session. We will build a fishbone together

DEBRIEF

- Examples from the group!
 - Why?
 - Why?
 - Why?
 - Why?
 - Why?
- What did it feel like??

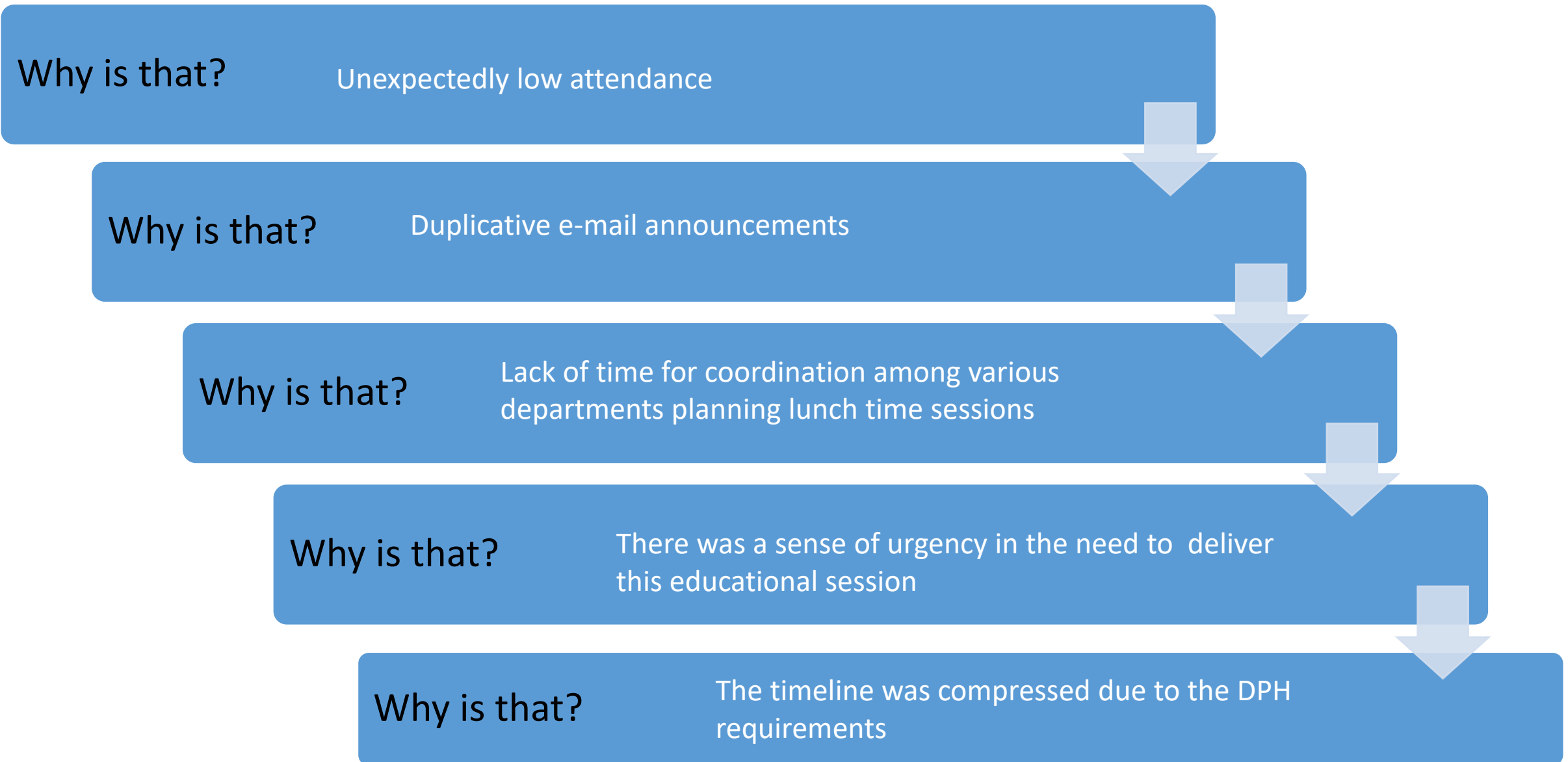
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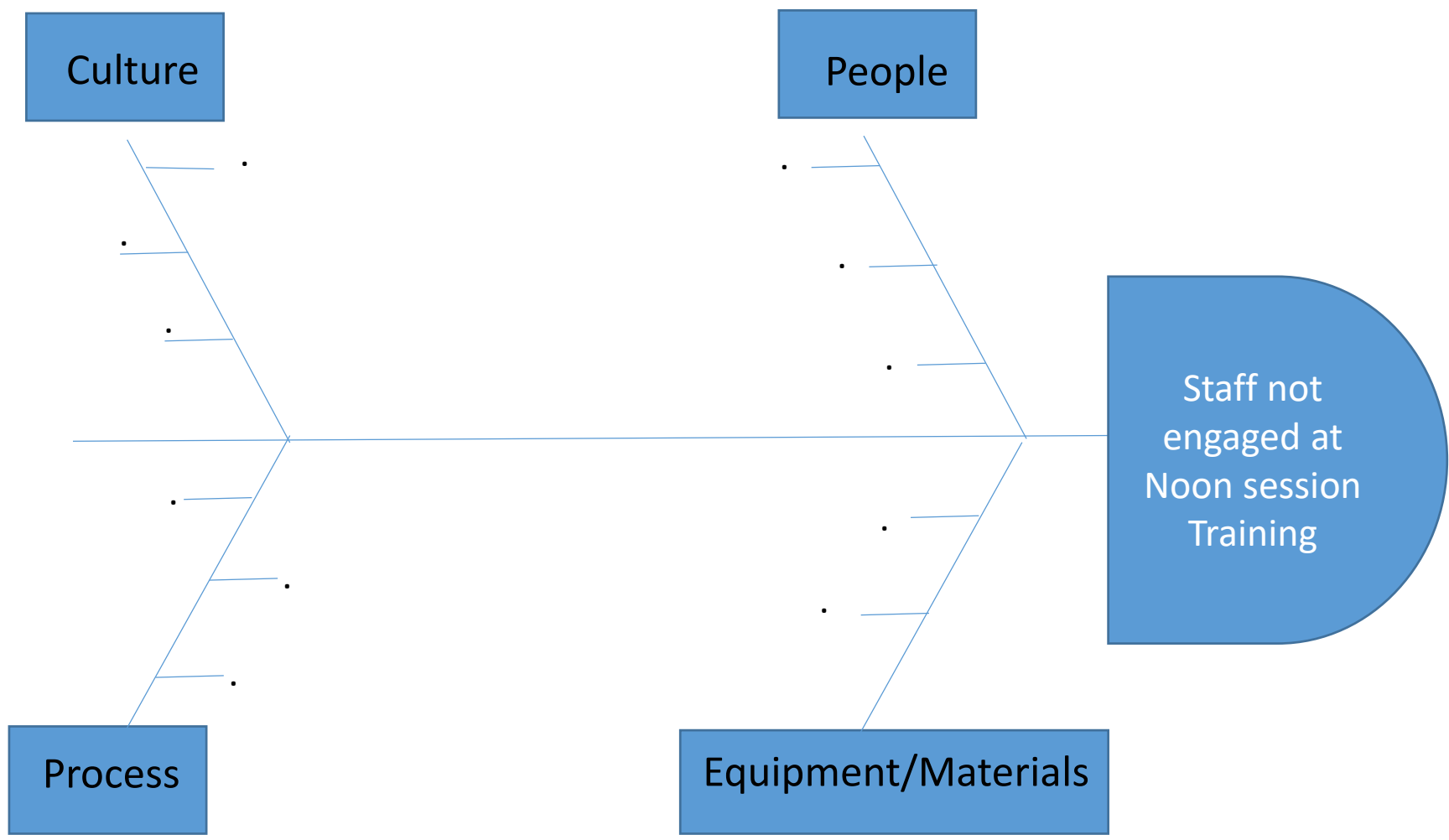
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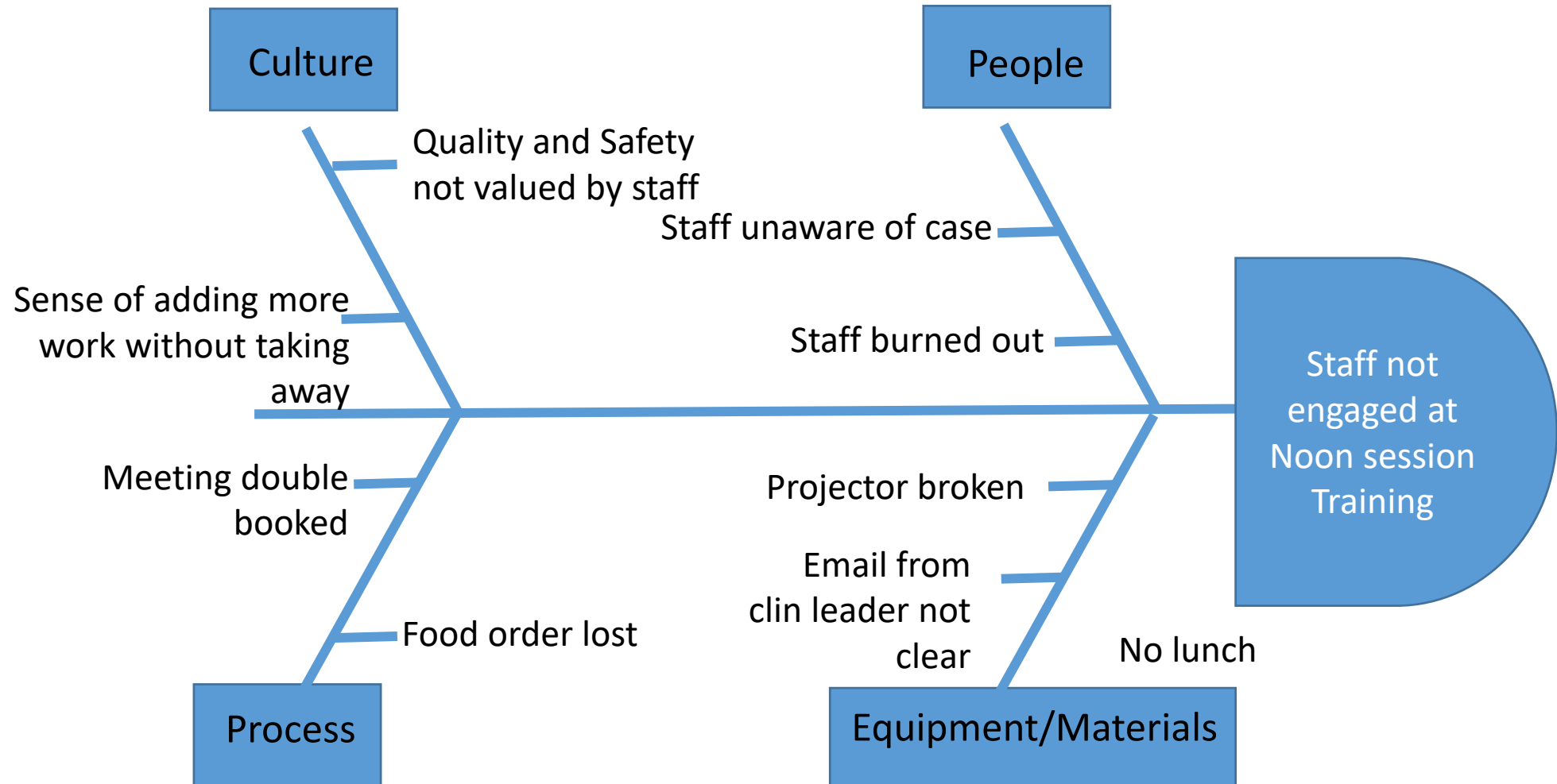
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DEBRIEF



Our version of the Fishbone!



Debrief

- How might you use these tools in your work??