Start

Hello,
I'm Sara.

I'm the RN and team leader of the TIPS team at Glastonberry Healthcare Center. TIPS stands for Team Improvement for the Patient and Safety. We learned about TIPS teams when we attended a national conference and then, later, from two journal articles, one called, Improving Disposition Outcomes for Patients in a Geriatric Skilled Nursing Facility and the other, Team Improvement and Patient Safety Conferences Culture Change and Slowing the Revolving Door Between Skilled Nursing Facility and the Hospital These really helped to inform our process.

I wanted to share with you how the TIPS team became one of the powerful interventions we used to reduce hospitalizations at Glastonberry Healthcare Center. We're proud to say that our reduction in rehospitalizations has reached 22%.

If you've got a few minutes, let me tell you what we did.

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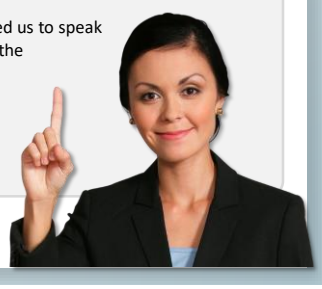
Who Makes Up a Tips Team?

- Who makes up a TIPS team?
- How does it work?
- Root Cause Analysis
- Tips Team Meetings
- A Few Other Details
- Resources

First, we adopted a philosophy . . .or, maybe better stated . . . an approach, that all re/hospitalizations were preventable. This was important because it caused us all to have a common starting position which led to better problem solving and brainstorming.

Nurses, nursing aides, physicians, therapists, social workers, and our administrator attended these meetings. Meeting times were varied to ensure that night and evening staff were included, and aides were compensated for attending TIPS conferences after their shifts had ended.

They were intentionally short! It forced us to speak directly about the issues that caused the Re/hospitalization.



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TIPS team meetings were held twice a month for 30 minutes, with the sole purpose of conducting a root cause analysis of hospitalization events.

The first 5 minutes, the case was presented. After this, the medical director facilitated a 15-minute group discussion, in which an explicit expectation was set for all attendees to participate. The final 10 minutes of the session was dedicated to the development of action steps.

Our team, though initially weak in conducting root cause analysis (RCA), became better and better at this skill as time went on. The trick was perseverance!

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Root Cause Analysis

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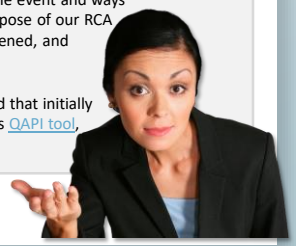
You, I'm sure, have been exposed to root cause analysis but, we were really surprised when we realized how poor we were at it! Only select members of our team really used it and of those, only a few had a real command or mastery.

RCA is a structured, facilitated team process that helps to identify the issues at the heart of events that resulted in an undesired outcome. From there, you can develop corrective actions. In our case, we were conducting a root cause analysis to determine anything that led to a rehospitalization!

RCA provides us with a way to identify breakdowns in processes and systems that contributed to the event and ways to prevent future events. Ultimately, the purpose of our RCA was to find out what happened, why it happened, and determine what changes need to be made.

One of the tools we used to practice RCA and that initially helped us to stay on track doing RCA was this QAPI tool, put out by CMS.



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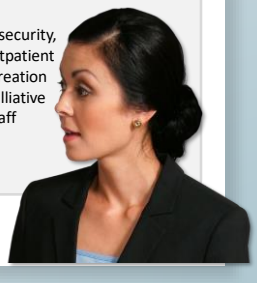
Tips Team Meetings

Before the TIPS conference, our medical director called the readmitting hospital and spoke with the hospital care team to gain insights into problems that might have been missed. According to the specific causes identified, additional information would be sought, and additional staff or outside experts were invited to participate in the TIPS session.

At the TIPS session, selected cases of rehospitalization were reviewed to identify ways in which the team could have operated more effectively. This had to be done in a way that focused on "systems" problems-not people. To get to the heart of the issue, there could be no shame or blame.

During the course of the year, representatives from security, maintenance, home care agencies, inpatient and outpatient pharmacies, information technology, psychiatry, recreation therapy, dietary, admissions, covering physicians, palliative care, respiratory therapy, families, and laboratory staff were included in the TIPS conference.



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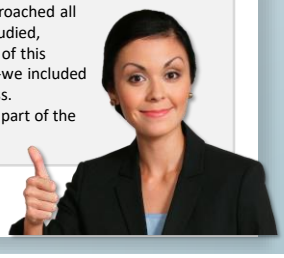
A Few Other Details

One way that we helped communicate all that we learned was by creating an email list of all direct care staff. We sent out a ''lessons learned'' email after each meeting to everyone-"tips from TIPS". It created a great deal of buzz and kept the conversations alive and in the front of people's minds.

Our front-line staff so appreciated being included in the dialogue.

With a great deal of diligence and perseverance, we worked our systems, massaging them, improving our skills and keeping our residents at the center of our care.

With a 22% decrease in rehospitalizations, I speak from experience. So, just to recap, these three actions were those that helped with our achievement. First, we approached all rehospitalizations as preventable. Second, we studied, practiced and taught all our staff how to be part of this work-we engaged them in a root cause analysis-we included people and made them feel a part of the process.
Lastly, we brought those voices together to be a part of the TIPS team.



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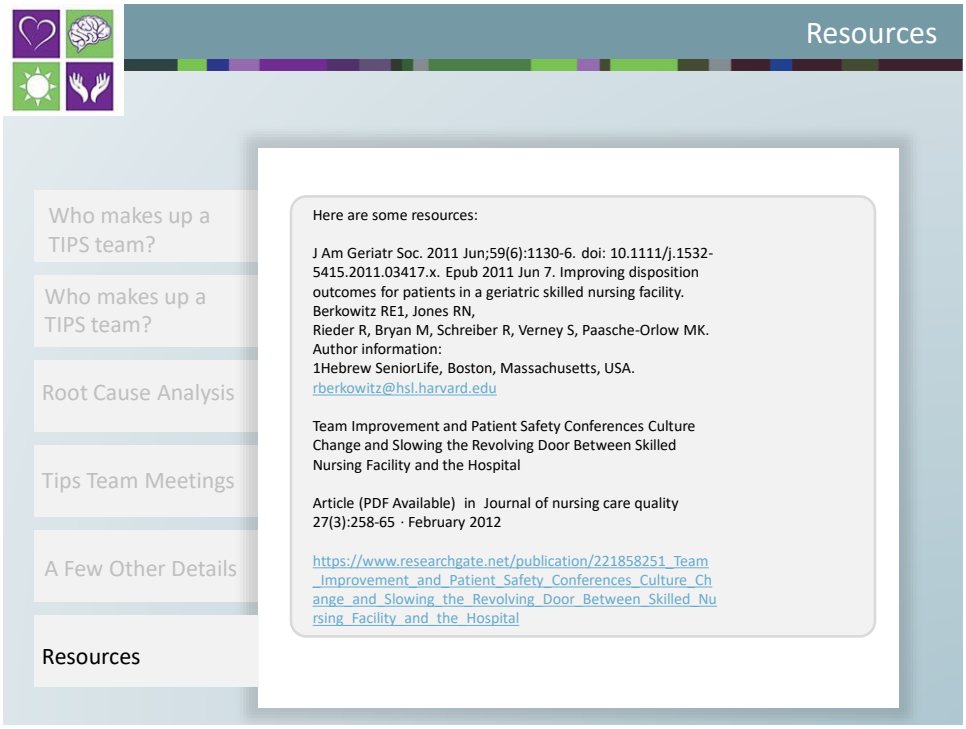
Resources
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Here are some resources:
J Am Geriatr Soc. 2011 Jun;59(6):1130-6. doi: 10.1111/j.1532-5415.2011.03417.x. Epub 2011 Jun 7. Improving disposition outcomes for patients in a geriatric skilled nursing facility.
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Team Improvement and Patient Safety Conferences Culture Change and Slowing the Revolving Door Between Skilled Nursing Facility and the Hospital
Article (PDF Available) in Journal of nursing care quality 27(3):258-65 · February 2012
https://www.researchgate.net/publication/221858251_Team_Improvement_and_Patient_Safety_Conferences_Culture_Change_and_Slowing_the_Revolving_Door_Between_Skilled_Nursing_Facility_and_the_Hospital

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