Daily Management System brings continuous improvement to life

System involves “everyone, every day”

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Marsha Maurer, RN

It’s 2 pm in the Finard 4 ICU. Nurse manager, Susan Holland, RN, walks to a bulletin board full of colorful charts and graphs. As staff gather in a semi-circle, Holland sets a five-minute timer. “Hi everyone,” she says. “We are starting a new People metric today based on your votes. We are asking, ‘Did handoffs occur at the bedside?’ So – how did that go today?” One by one, staff members report in on whether the metric was met. As part of the discussion, staff realize that not everyone has the same understanding of what a bedside handoff entails. Holland facilitates a discussion that brings staff to a better shared understanding of the standard. She says that day one of examining a new metric is a perfect opportunity to clarify expectations on a quality goal, and to strategize how to improve performance. It’s all part of the new Daily Management System (DMS) – a method of continuous improvement that is owned by front-line staff, and enables them to respond to quality issues in an immediate and continuous fashion. Leaders say it’s a way for “everyone, every day” to be involved in quality improvement efforts at BIDMC.

Small steps to success

Members of the leadership team in patient care services have been studying and using Lean process improvement methods for some time. As part of this work, they began to explore the Daily Management System. A delegation learned more by traveling to health systems where it was in use. They were looking for nimble, dynamic ways to improve quality one step at a time. Marsha Maurer, RN, senior vice president for patient care services and chief nursing officer, notes, “Managers who are tackling quality goals start to feel ‘initiative overload.’ Everything feels like an add-on. We realized that if you build a simple, front-line method for doing improvement work that can be owned by the people doing the work, you are going to have the best chance at success.” Maurer convened a Steering Committee charged with exploring how the DMS could be implemented at BIDMC. Co-chaired by associate chief nurses Elena Canacari, RN, Cindy Phelan RN, and Kim Sulmonte, RN, the group quickly realized that the first task would be to give leadership staff at all levels the...
time they needed to focus on improvement work.

**The gift of time**
Steering Committee member John Ryan, RN, nurse manager on Farr 9, led a subgroup that looked at the calendars of the leadership team and asked – How can we free up time for improvement? Can we create a “Standard Calendar,” where there are blocks of protected “no meeting” zones each week?

As a first step, Ryan’s group set out to scrutinize all regularly occurring meetings within PCS in order to see what could be trimmed. Ryan notes, “Meetings are extremely valuable and serve a purpose. But it’s also important for managers to be present and available on their units to support staff and help them tackle problems.” Leaders were surveyed and asked to report in on how many meetings they attended, and to examine each meeting and ask: Is it still needed?

If so, can the frequency or length be reduced? Can one meeting perhaps dovetail and combine with another? Phelan says, “The more we questioned, the more opportunity we found! It turned out we could eliminate, combine, or simplify meetings and not impact the results we had set out to achieve when we created the meeting in the first place.”

What emerged after the survey process was a drastically reduced slate of meetings within patient care services, with total meeting time going from 173 hours to just 73 hours per month. From there, a Standard Calendar was devised in which people were asked to respect three “no meeting” zones of two hours each throughout the week. Commenting on the zones, Maurer notes, “Not only does this provide predictable time to do the work of quality. It also enables leaders like the associate chiefs, and myself, to be present at the local level and observe and coach the work that is occurring.”

**How it works**
Alison Small, RN, nurse manager on CC6A, headed up a second subcommittee looking at the implementation of the DMS itself. Her group oversaw a training process and pilot implementation on CC6 and devised a unit-by-unit rollout.

The work of the DMS occurs in five-minute daily “huddles,” attended by all staff on the unit that shift. The entire staff has input into two metrics to focus on during the huddle – one looking at clinical care, and one “people” metric that looks at work flow and teamwork. The metrics must be chosen by the staff, important to the group, and easily measured on a daily basis. As they huddle, staff use a bulletin board with “calendars” in the shape of a “Q” (for quality) and a “P” (for people) to track whether the metric was met. A red square signals the metric wasn’t met that day, a green square means it was. Maurer says it’s called the “5 feet/5 seconds” principle. She explains, “If you are standing within 5 feet of the board, within 5 seconds you have an idea of what is going on.” The huddle leader, who can be any member of the staff, encourages participants to brainstorm as to why things did or did not go as expected. Ideas on how to improve are recorded on the board. When the goals set by the staff for each metric have been met, that metric is sunned and a new measure is chosen. Small says that chunking improvement efforts into small, manageable steps makes a lot of sense. She shares, “You can’t make a huge change all in one day. But what you can do is make small changes that make a big difference over time.”

**Quality metrics**
As DMS has rolled out, a variety of quality metrics are being successfully tackled at the unit level. Sheri Paquette, RN, clinical advisor on Farr 3, says one metric her unit addressed was recording patients’ daily intake and output (I and O), which is a measure that is particularly important in patients with heart failure. Paquette notes, “We didn’t think we had a problem with I and Os. We thought we were doing...
really well. When we looked at it — we were not as great as we thought.” The staff thought a goal of 80% accuracy in I and Os was a good beginning target, but found they were “nowhere near” that mark. Paquette says the staff identified and solved problems such as: misunderstandings as to the volume of various drink containers; confusion as to how to properly record when patients had “zeroes” in either the intake or output column; receptacles in the patient rooms that measure output not always being where they should be; lack of standardization regarding how to document the full day’s I and O for patients who are transferred to the unit; and more. As this metric was revisited every day, ideas on how to solve these problems were discussed. The ideas were put in place and significant improvements were achieved. Staff met their 80% accuracy target and were able to sunset this measure.

On Holland’s unit, the staff chose to focus on reducing transcription errors in the medication administration record (MAR). Holland says that because the Finard 4 MAR is still paper-based, physician orders need to manually move from the order entry system to the paper chart, and errors can occur. Holland says the staff discussed their practice of checking the MAR against the physician orders once a day and realized it was not enough. They added a second reconciliation each day as part of change of shift handoff and saw a significant drop in errors.

**People metrics**

Every huddle also includes some metric having to do with the people doing the work. Units have chosen to measure things like whether staff got out of work on time or whether staff coming on shift received all the information they needed. Maurer says the focus on people metrics has had an unexpected benefit, one that she hadn’t observed or heard about in the hospitals she visited that had DMS in place. She notes, “We are seeing the ‘people’ metrics have a cultural impact. People are being challenged to look at how they work together.” Paquette has done a lot of coaching with the Farr 3 staff on this topic. In one of her regular “DMS update” emails to staff, she commented, “Keep in mind how we can deliver quality feedback, especially in a public forum like the DMS huddle. Most people would like to know how to improve, and they deserve to know.” Maurer comments, “This work has created a new way for staff to identify and solve problems related to teamliness, collaboration, and workflow.”

**The way we do the work**

Maurer says that rather than being another in a list of projects that managers and staff see come and go, she wants the DMS to be baked into the culture. “This is now the way we improve the work,” she says. “It’s truly a continuous improvement system.” She believes that allowing staff to focus on what matters most to them not only ensures a high degree of success, but also will lead naturally to positive movement on more broadly defined institutional goals. She notes, “Multiple small successes at the unit level builds our organizational quality in a way that naturally aligns with broader improvement goals set at the organizational and industry level. When you’re in that state of continuous improvement – for everyone, every day – improvement becomes routine.”

**Tracking progress**

During five-minute Daily Management huddles, staff report out on improvement metrics they have chosen. Monthly calendars in the shape of a “Q” (for quality) and a “P” (for people) provide a way to track progress. Red means the standard was not met that day; green means it was. On Farr 3, staff recently saw significant progress in the accuracy of intake and output measures, after they identified barriers to meeting the standard and brainstormed solutions.