

# Managing Daily Improvements: Engaging Staff Nurses in Quality and Process Improvement

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## Purpose

- Develop a culture of nurse engagement in process and quality improvement
- Promote problem solving and ownership on the unit level
- Decrease unit patient fall rates

PICOT Question:

**On an inpatient cardiac telemetry unit (P), how would implementation of a Managing Daily Improvements (MDI) board (I), compared to quarterly audits/passive reporting (C), affect employee engagement and patient fall rates (O) in 2022 (T)?**

## Background

- Project unit is a 43-bed cardiac telemetry unit, with 34 beds in operation as of March 1st, 2021. Average daily census is 29 patients, with a case mix index of 1.4. This unit has the highest patient discharge rate in our facility.
- Unit has a high amount of nurse travelers and has historically had frequent turnover in leadership. At the time of project initiation, unit manager and director employed in positions less than 1 year.
- Despite having a hospital policy with fall prevention bundle, fall events on Telemetry unit were high. Auditing revealed that key elements of fall prevention bundle were frequently missing.
- Quarterly falls bundle audits are completed by hospital fall prevention team, with feedback given to staff and leadership. No routine discussions or feedback regarding falls otherwise occurring.
- 33 falls between July 1, 2021, and December 31st, 2021. Annualized fall rate for 2021: 66.

### 2020 Employee Engagement:

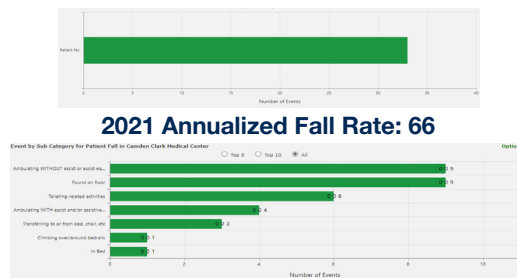
My Leader supports quality improvement: 3.88

My ideas and suggestions are seriously considered: 3.33

I am involved in decisions that affect my work: 3.24

3.24

I am involved in identifying and implementing performance improvement activities within my department: 3.58



## Process Description

- Director/manager led Pick Chart discussions during shift huddle
- Met with and trained nurse manager and all charge nurses to use of MDI board, PICK chart
- Management and staff designed MDI board
- Incorporated MDI board into existing shift huddles
- Heavy focus on idea generation initially
- Put ideas into action
- Test of change/cycles of PDCA
- Discussions on each shift regarding how tests of change were going
- Nurses picked metric to follow for falls and track each shift on MDI board
- Red/Green for each shift with metric tracked
- Fall-outs discussed with root cause identified



Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Safety  Quality  Productivity  Cost

Describe the Problem (plain language & explain why others should care too):

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5 Whys:

Why? \_\_\_\_\_

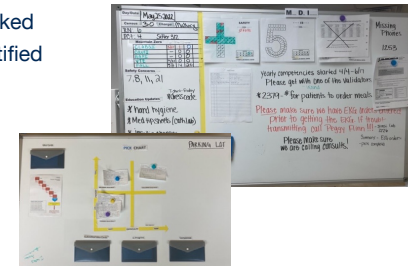
Why? \_\_\_\_\_

Why? \_\_\_\_\_

Why? \_\_\_\_\_

Why? \_\_\_\_\_

Countermeasure:



## Results

### 2022 Employee Engagement:

My Leader supports quality improvement: 0.67

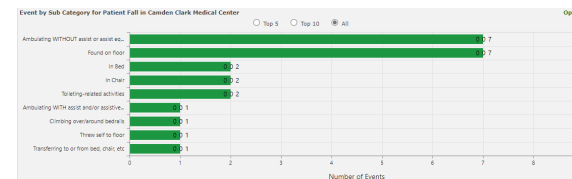
My ideas and suggestions are seriously considered: 0.22

I am involved in decisions that affect my work: 0.42

I am involved in identifying and implementing performance improvement activities within my department: 0.32



**2022 Annualized Fall Rate: 32**  
**52% Decrease in Falls**



## Implications for Practice

The opportunity existed within this nursing unit to improve patient outcomes and increase staff nurse engagement. A nurse driven approach, using Managing Daily Improvements methodology, has the potential to improve patient outcomes and unit operations. It provides a framework for a staff driven approach to problem solving, while increasing nurse engagement and perception of overall autonomy in decision making.

## Recommendations

Based upon the use of an MDI board on this unit, which resulted in both increased safety outcomes for patients as well as increased nurse engagement, it is recommended to continue to use this approach, and to replicate the use of the MDI board on other units within the organization. Further data collection, observation, and leader coaching is recommended to ensure continued stability of process, staff adaptation to use of board, and overall sustainment of method. If spread outside of the service line, collaboration with and training for other nurse leaders should occur.

## References

- Liker, J., & Meier, D. (2006). The Toyota way fieldbook. New York, NY: McGraw-Hill.
- Mann, D. (2015). Creating a lean culture: Tools to sustain Lean conversations. Boca Raton, FL: CRC Press.
- Meier, A. (2017, April 14). NEP MDI huddle. Retrieved from YouTube: <https://www.youtube.com/watch?v=KN-Swa36PB8>