Spring 2018

Standardizing and Magnetizing Improvement Projects

Brittany Kyle
brittkyle@aol.com

Standardizing and Magnetizing Improvement Projects

Brittany E. Kyle

University of San Francisco

Table of Contents

Acknowledgements

With much gratitude, I would like to dedicate this work to everyone who has helped me complete this Doctor of Nursing Practice journey. I never truly understood the meaning of "it takes a village" until I began this process.

To my parents: who have always taught me the value of education, to believe in the power of my dreams, and the work ethic to achieve them. Everything I do is to make them proud. In remembrance of my beloved grandmother who lovingly started this journey with me, but sadly is not here to finish with me.

To John Muir Health: for its unwavering support of my career and education. I have had more opportunities to advance my career that I could have ever imagined-- for which I will be eternally grateful. My nursing leaders at John Muir Health have also provided unconditional support and assistance for my education; without it would never have been able to finish.

To my colleagues, who are also some of my best friends. Thank you for always encouraging me through this process and being there to support me when it got tough. Every day you show me how to be a better nurse, leader, friend, and person. You all are my tribe.

To the University of San Francisco for allowing me the opportunity to get the best education possible for both my MSN and DNP. What I have learned will make be better forever.

With humble gratitude and appreciation, I would like to thank my advisor Dr. Juli Maxworthy for all the guidance, support, and for pushing me to be better. Also to Dr.

Elena Capella for being a valuable member of my committee, and for providing instrumental feedback on my work.

Section I- Title and Abstract

Title

Standardizing and Magnetizing Improvement Projects.

Abstract

Recent changes to healthcare reimbursement models have forced hospitals to improve their quality of care while reducing costs. John Muir Health has adopted the Performance Improvement philosophy to address these challenges. However, the current state for improvement project design is not standardized and does not guarantee that Magnet© standards will be followed. This design has caused confusion, inability to achieve project goals, and dissatisfaction among team members. The inability to achieve project goals has resulted in an ineffective use of resources and redundant work.

The objectives of this project were to standardize the way improvement projects are reviewed utilizing the Iowa Model of Evidence-Based Practice to Improve Quality Care, and to create a Magnet© toolkit for following the correct standards for improvement projects and data collection. A standardized process allows the proper stakeholders to be involved in the improvement project, which in turn allows achievable and appropriate goals to be set. Achieving the defined goals will improve patient safety and quality. It is also important for a Magnet© designated facility to use an evidence-based approach for improvement projects.

A standardized process was created that will allow the proper stakeholders to be engaged from the beginning of the project. Due to significant changes in the hospital leadership structure, the proposed interventions could not be implemented. As a remedy to this challenge, an online educational module was created that provides all the

education and materials necessary to implement the interventions in the future. An online educational model was also created that describes Magnet© data collection standards to ensure that improvement projects are always compliant with Magnet© standards.

Keywords: *magnet, quality, improvement, standardization, program development*

Section II- Introduction

Improvement projects have the ability to improve patient outcomes while reducing cost and waste. However, non-standardized processes did not allow a large community-based healthcare system to fully capitalize on these potential benefits. While the institution does utilize accepted Performance Improvement methodology, it is lacking a formal way to engage and involve all the stakeholders from the inception of the project. Often, the team leader was not familiar with the departments involved with the project, so they are not able to engage the necessary stakeholders or ensure appropriate project participants. Once the project was underway, the team would often identify stakeholders and departments that were important to the improvement project but were not represented. When the omitted department was eventually contacted to request their participation, the engagement and willingness to participate was minimal due to the perception of being an afterthought in the process. This caused the project or initiative that was requesting the additional participants to be less effective and productive with the projects' initial goals.

Not being able to meet the goals of the project results in increased costs for the organization because resources were dedicated to a project that did not produce any tangible results. Also, the health system is not able to capitalize on the intended cost saving or cost avoidance that were expected outcomes of the project (Lovlien, 2007; Bokhoven, Kok & Weijden, 2003).

Not having a standardized way to communicate projects or initiatives that are being conducted throughout the organization has caused duplicate work to be done by various leaders and departments; sometimes creating conflicting changes. Another

consequence of non-standardized processes is that there is not proper leadership support to sustain changes that were designed by the quality and performance improvement team.

To address the challenges with improvement projects, a standardized process was created that allows all the stakeholders to be engaged from the start of the project (Strating, Nieboer, Zuiderent-Jerak & Bal, 2011; Reed, McNicholas, Woodcock, Issen & Bell, 2014). The original plan for the project was to pilot the new standardized process on an improvement project being conducted in the hospital, then to survey participants about their satisfaction with the project and outcomes. The Chief Nursing Officer (CNO) and the Nurse Executive Council (NEC) approved the project and interventions in March 2017. The letter of approval from the CNO is in Appendix A.

Due to significant changes in the health system's leadership structure, beyond the control of the DNP student, there have not been any performance improvement projects conducted in the last twelve months; therefore, the newly designed standardized process could not be implemented. John Muir Health began an initiative of transformation and integration which involved a complete re-design of the health system's leadership structure that included: changes in various leaders' job descriptions, new positions, elimination of positions, and re-assignment of current leaders. The initiative also began to merge the health system's two acute care hospitals, which will affect the implementation of future improvement projects. All these changes have caused unease and turbulence amongst staff and leaders. Due to these circumstances, no other projects or initiatives have been started since the beginning of 2017.

The DNP student was in contact with the CNO from March 2017 to October 2017 about prospective projects that could be used to pilot the new standardized process. A

potential initiative was identified (though not an improvement project) to implement the concepts, however the initiative was also placed on hold because its launch was set to occur during the week of the devastating Northern California wildfires. This event caused the hospital to be on "Code Triage" for many days, which suspended normal hospital operations. Engaging leaders in a new initiative during this time was not only deemed insensitive to the situation but was also determined to not be a priority for the health system at that time. It was determined by the student and advisor that proceeding with the implementation as planned would be sub-optimal because the stakeholders would not be fully engaged in the interventions due to the effects of the wildfires on the health system and surrounding community.

To address the implementation challenges, an online educational module was created that provides all the tools and necessary education to implement the new process in the future. This module is available through the health system's online education platform, so they will be able to be viewed at any time.

As a Magnet© designated facility, there are strict data collection standards for any project that is done throughout the medical center. Unfortunately, these standards are not always maintained which puts the facilities' re- designation at risk. To address this problem, a toolkit was created that described the Magnet© data collection standards (Taylor, 2005). It is also available through the online education platform and can be viewed at any time.

Problem description

At John Muir Medical Center, Concord Campus, quality and performance improvement projects were not conducted in a structured way, and any member of the

leadership team could initiate a project. This caused instances when important stakeholders were not involved in the planning, goal setting, or implementation of a project. Previous quality and performance improvement project leaders and participants observed that when the proper stakeholders were not included in the planning phase of the project, the opportunity to set achievable and appropriate goals were often lost. The non-standardized process also caused a deviation from the Magnet© data collection standards for quality and performance improvement projects because it was not a priority to include these elements and many project leaders were unaware of the Magnet© standards. This state has caused duplicate work, increased costs, extreme frustration among the team members, and does not provide a return on investment for the resources that were dedicated to the project.

These inconsistencies have caused frustration among project participants and stakeholders, the inability to set and achieve projects goals, and ineffective use of resources at John Muir Health. The newly developed and evaluated modules will assist in ensuring that a standardized process will allow the appropriate stakeholders to be involved in the planning phase of the project. This will ensure that: the proper participants are selected for the project, adequate resources are allocated for the project, and that the team is able to set appropriate and achievable goals. Planning improvement projects appropriately will set the team up for success and provide a better return on investment for the resources that were dedicated to the project. The return on investment will be dependent upon the trigger and goals of the project such as improved patient satisfaction, improved patient outcomes, or decreased hospital- acquired conditions, all of which have financial implications for the healthcare system.

Available knowledge

PICO question. In acute care hospitals, how does a standardized approach to quality improvement projects, compared to a non-standardized approach, affect quality care and patient safety?

A literature review was conducted from December 2016 through February 2018 of articles written from 2006 to 2018 using the keywords: *magnet*, *quality*, *improvement*, *standardization*, and *program development* using the CINAHL and PubMed databases. Limits were set to only include peer-reviewed articles written in the English language, date limits were not set due to lack of articles meeting the inclusion criteria being published in the last five years. Three thousand articles were initially found, and 18 met the inclusion criteria and were included in the literature review. The Johns Hopkins Evidence Appraisal tools (Johns Hopkins Hospital/The Johns Hopkins University, 2012) were used to evaluate each article. The articles were rated at a strength range of level III through IV and quality level B. The evidence table is displayed in Appendix B.

Overall, the literature supports the use of performance improvement projects to improve quality care and patient safety. Despite the use of projects to improve outcomes, there is a very little evidence about how to standardize and implement improvement projects (Lovlien, 2007; Bokhoven, Kok & Weijden, 2003). There is also very little information available about the quality improvement competencies that should be utilized to aid healthcare facilities with their quality improvement projects (Czabanowska et al., 2012). While many articles describe their approach in detail, only two articles described the use of an established evidence-based approach, The Iowa Model of Evidence-Based Practice to Promote Quality Care. Despite the lack of standardization, all the articles

reviewed were clear that effective planning, stakeholder engagement, and agreement on project goals were essential steps to ensuring project success.

Iowa model of evidence-based practice to promote quality care. Two articles, Brockman (2015) and Murphy (2013) used the *Iowa Model of Evidence-Based Practice to Promote Quality Care* to conduct different projects—and the model was found to be an effective tool for planning and implementing their respective projects. The Iowa Model is an evidence-based tool that clearly and methodically walks through the steps of an improvement project from beginning to end (Brockman, 2015).

Brockman (2015) used the Iowa Model of Evidence-Based Practice to Promote Quality Care to implement the mother-baby model of nursing care a labor and delivery unit and newborn nursery. These units were combined in order to decrease staffing needs, increase mother-baby bonding, improve clinical outcomes, and increase patient satisfaction. The author states that using the model allowed their project to be effective because they were able to engage staff and other stakeholders in an organized and evidence-based manner. Brockman (2015) reports the unit was able to meet productivity and staffing goals, increased clinical outcomes (measured by breastfeeding rates), and had a 96.5% patient satisfaction rate.

Murphy (2013) utilized the Iowa Model for Evidence-Based Practice to reduce falls in a medical-renal unit that had an above average number of falls. A multidisciplinary team was created and implemented several interventions to reduce falls. The author states that the Iowa Model of Evidence-Based practice was effective because it used an interdisciplinary approach, and has feedback loops that allow for continuous monitoring, follow up, and evaluation. The falls on this unit dropped 67% over three

months. The facility where this medical-renal unit was located adopted the Iowa Model for all improvement projects moving forward because of the success they had in reducing falls.

Standard approaches to improvement projects. In several articles, the authors described their own methods of standardizing an approach to projects. While the methods used are different, the basic themes are clear: a solid foundation of goals and stakeholders is essential for the project to be successful.

Cedars-Sinai Medical Center, a facility well known for being on the cutting edge of medical care, has created a standardized way to review their improvement projects. Cedars-Sinai utilizes a Quality Council which their governing body allocates resources and prioritizes improvement projects for the organization. The quality council also monitors performance measures and manages communication amongst the project stakeholders (Bolton & Goodenough, 2003). Once a project is allocated through the Quality Council, it is sent the appropriate subcommittee for implementation called the Performance Improvement Committees (PICs).

An article by Matinheikki, Artto, Peltokorpi and Rajala (2016) stated that there is an important pre- project step. This step defines the goals, expected value of the project, and project requirements. The authors also state that a project's success is dependent upon successful alignment of the project goals. This is important because if the goals are not clear the team leaders and members will not have a clear direction for their proposed changes and interventions. Without that clarity, the expectations of the individual stakeholders will not be met, resulting in ineffective project outcomes.

Reed et al. (2014) described an approach that was used to design quality

improvement initiatives called the Action Effect Method (AEM). The first step is defining the aim, which includes: the goal of the improvement project, scope, and consensus from stakeholders. The goals and evaluation methods are agreed upon in the first step in planning so that the interventions can be guided accordingly to achieve the desired outcomes. The intention of creating the AEM model was to provide a visual model to lead quality improvement projects. The authors discuss that this model provided a platform to further investigate theories to facilitate performance improvement projects. This article describes how AEM can be applied to an improvement project, but was not applied to a particular project.

Magnet© standards. Magnet© standards are designed to promote quality nursing care and positive patient outcomes, which is why making them standard practice for implementation of improvement projects is critical (Taylor, 2005). Nurse sensitive indicators (NSI) are examined during the Magnet© designation process. Successful improvement projects will potentially improve these NSIs, making adherence to evidence-based practice and Magnet© standards incredibly important (Bakker & Keithley, 2003).

Rationale

The literature was clear that a standardized approach to improvement projects is essential to its success. Additionally, using an evidence-based practice tool in the care of patients was an essential approach for a Magnet© designated facility. This is important because it is becoming increasingly imperative to adhere to these standards because Magnet© designation is becoming more difficult to achieve and maintain as the expectations for Magnet© facilities are continually rising (Smith, 2007). Furthermore,

Magnet© standards now expand beyond nursing to all disciplines involved in hospital operations (Smith, 2007) which makes it imperative that stakeholders from across the organization are involved in the planning, implementation, and evaluation of improvement projects.

As healthcare changes to pay for performance and value-based purchasing models it is important for healthcare organizations to continually improve their quality and safety. This has created an increased demand for effective and efficient performance improvement projects (Strating, Nieboer, Zuiderent-Jerak & Bal, 2011; Reed, McNicholas, Woodcock, Issen & Bell, 2014).

Baseline qualitative and quantitative data was obtained from past project participants to identify their satisfaction with the project goals, leadership support, and project structure. Survey questions were adapted from the Agency for Healthcare Research and Quality's (AHRQ) quality improvement toolkit and the Performance Improvement methodology, DMAIC (design, measure, analyze, improve, and control) (AHRQ, 2017; Kubiak & Benbow, 2009). The DMAIC methodology is a systematic way to proceed through the improvement process. Therefore, the survey questions assessed the participant's satisfaction with the five steps.

This author distributed the survey to twenty past project participants but because these individuals had participated in the past there was a need to have them rely on their memories. The survey was only to be distributed to those individuals who were still part of the organization. Seven survey responses were received. The results were widely varied, consistent with the hypothesis that there was varied participant satisfaction and leadership support for quality and performance improvement projects.

Many project participants and leaders have expressed frustration during the progression of quality and performance improvement projects. Comments would often follow the theme of why a certain participant, department, or stakeholder was not involved.

The qualitative and quantitative data was used to drive the project by showing that there was a great range in satisfaction. Graphs and more details of the survey results are displayed in Appendix C. The survey results were consistent with the qualitative data collected from previous project participants and leaders: they have experienced inconsistent levels of project satisfaction and leadership support. The root cause based on feedback received appeared to be due of the lack of leadership support and engagement by leaders at the beginning of the project. Previous project participants have also observed that often times the hand chosen team members were not the best choice, as they were chosen based on their department or specialty, which caused an inefficient use of resources and participant's time. Participants also voiced frustration with the hospital leaders that were involved; if the proper leaders were not involved, support for the changes the group suggested did not gain the desired support to move forward simply because the person to support them was uninvolved. Additionally, various individuals have expressed concern about the way that leaders were engaged in the project because they were asked to make changes, at the recommendation of the team, but were not fully informed about the reason for the change. During improvement projects, the involved leaders attend a daily "report out" where the team members explain the solutions and actions that were discussed during the day. This "report out" also includes the justification for these actions, and the resource requirements from hospital leadership.

Many leaders have been omitted from this process but were still expected to provide support or resources as part of the solution. This situation was disappointing for the team members and the leaders because the team members did not receive the support they were asking for, and leaders were not able to provide it because they were not involved in the process.

Conceptual framework. Two theories were used in the development and implementation of this project: Logical Theory and Kotter's Change Model. These theories were chosen because of their simplicity and applicability to the project goals. Also, Kotter's Change Model is currently utilized by the facility in their Magnet© documents. The Logical Theory was used to plan the project and Kotter's Change Theory was used to implement and maintain the interventions.

***Logical theory*.** The Logical Theory uses backward planning to build vertical logic by starting with the goal and moving backward in a methodical way to identify what is necessary to achieve the desired outcomes. The project is planned in the following order: 1. Identify the goal 2. Results 3. Objectives 4. Outputs 5. Activities 6. Inputs. (Goeschel, Weiss, & Pronovost, 2012). The project was aligned with the Logical theory in the following ways:

goal. Improved safety and quality through successful improvement projects that meet the desired goals and outcome measures.

results. A standardized process to plan improvement projects and identify stakeholders in order to set appropriate and achievable goals.

objectives. Present proposed projects to hospital Nursing Directors: each person will decide if their department has a stake in the project.

outputs. Support from the hospital leaders and Nursing Directors.

activities. Literature review that will identify the best practices for standardizing improvement projects.

inputs. Current state data. A presentation was given to Nursing leaders about the way projects are currently designed and the lessons that have been learned. Examples of how the goals of previous improvement projects were not met due to ineffective planning will be used to make the case for the proposed interventions. Due to the challenges of the project implementation, the elements basically stayed the same but how the goal was achieved was altered.

Kotter's change theory. The eight steps of the model are: 1. Create a sense of urgency 2. Build a guiding coalition 3. Form a strategic vision and initiatives 4. Enlist volunteer army 5. Enable action by removing barriers 6. Generate short -term wins 7. Sustain acceleration 8. Institute change (Kotter, 1996). The initial project plan was aligned with Kotter's Change Theory in the following ways:

create. Creation of a standardized process.

build. Decide on the proper venue for presenting proposed projects and where stakeholders will be able to identify themselves.

form. Engage the identified stakeholders.

enlist. Identify team members and gain support from nursing and hospital leaders.

enable. Provide education about current state and associated opportunities.

generate. Perform a small improvement project to show that results are achievable and share success with leadership and stakeholders.

sustain. Assess interventions and make changes as necessary.

institute. Develop maintenance plan once interventions are deemed effective.

Again, due to the challenges of the implementation phase of this project, the elements remained constant but the path to the change was adjusted. Visual models of the theories can be found in Appendix D.

Specific aims

By December 2017, assess, develop, implement, and evaluate a standardized way to assign, implement, and manage improvement projects at a Magnet© facility.

Goals and objectives The goals of this project were:

- Create a standardized way to request, review, and plan hospital -wide improvement projects by utilizing the Iowa Model of Evidence -Based Practice to Improve Quality Care.
- Create a toolkit for adhering to Magnet© standards when conducting and improvement projects.

Section III- Methods

Baseline data was obtained that showed the need to adjust improvement project design, implementation and evaluation. Therefore, a standardized process for planning, designing, and evaluating improvement projects was developed that utilizes the first three steps of the Iowa Model for Evidence- Based Practice to Promote Quality Care to guide the project. The standardized process was designed based on the feedback obtained from the pre-assessment data that demonstrated the need of improvement project design. The DNP student met with the CNO, the Nurse Executive Council (NEC), and the Magnet© Program Director while designing the new standardized process to ensure that the new

process best meets the needs of the organization. Once the process was designed, the DNP student and the CNO attempted to find an improvement project being conducted in the organization to trial the new standardized process. Once the project was completed, the intention was to survey the participants and leaders about their satisfaction with the project design using the same questions that were asked to obtain pre-implementation data.

Unfortunately, due to a moratorium on initiating improvement projects occurred throughout the health system in 2017 (time of DNP project) due to system -wide changes in the leadership structure. Due to this barrier, which had been thought initially would only be a challenge for a few months but ended up being for many months, an alternative was developed which was an online educational module utilizing the learning platform Knowledge Center was created. This module contains all the necessary information and tools to implement this process with the next improvement project. This module was developed based on the baseline data that was obtained from previous project participants and distributed to various nursing councils throughout the organization to obtain their feedback. Once feedback was obtained, identified changes were made to the module. During the process, individuals who were involved in the process were then surveyed about their satisfaction with the process and likelihood of implementing the process in the future. Nursing leaders, Professional Development Specialist, (formerly Nursing Educators) and nursing councils were supportive of the new standardized process and are looking forward to the opportunity to trial the newly designed process.

In addition, an educational module describing the Magnet© standards for data collection was also created to ensure that data collection standards are met at all times.

Not only will this ensure that projects can be used in the Magnet© document to achieve re-designation, but it is imperative that the organization holds itself to the highest standards at all time in accordance with Magnet© standards. This module was developed in concert with key individuals and reviewed by the Magnet© Program Director and subsequently approved for use by team members when improvement projects are reinstituted within the organization.

Context

The setting for the project is John Muir Medical Center, Concord Campus. The hospital is a community, not for profit, and Magnet© designated hospital with approximately 200 beds. The Chief Nursing Officer approved the project (Appendix A). During the implementation of the project, John Muir Health began an initiative to integrate the Concord and Walnut Creek Medical Centers. This meant that future performance improvement projects will involve both hospitals, which was not accounted for in the initial project plan. Because this project started prior to this system -wide integration, only project participants from the Concord campus were surveyed, and only nursing leaders from the Concord campus were involved in the planning and development of the project. In the future, members from both campuses will be utilizing the developed modules to assist with ensuring consistency with quality improvement projects across the system.

Stakeholders. The key stakeholders for this project were the DNP student, the Chief Nursing Officer, nursing and hospital leadership, performance improvement leaders, quality management, and any project participants.

Project participants, including nursing leaders, were aware of the need for the intervention and very open to adopting the change. Nursing leaders and stakeholders who were not aware of the current state were very open to the project once the problem was presented to them stating, “that makes perfect sense” and “why haven’t we thought of this before?”.

Identifying stakeholders was challenging for this author because of the significant changes to the leadership structure. As leaders’ positions and responsibilities were evolving, so were the stakeholders who should be included. Ironically, the same unstandardized process that makes improvement projects challenging made identifying and engaging stakeholders challenging.

Interventions

To ensure consistencies of improvement projects, the literature indicated that the IOWA Model would provide a framework that could guide the work in a consistent manner. Once the model was provided to the key stakeholders and approved for utilization, the implementation strategy became clear. There were five critical steps in the process and those included:

1. The team leader determines the reason for the project based on criteria listed in the Iowa model.
2. The team leader submits the standardized form to the Nurse Executive Committee (NEC) and the Management Communication Meeting
3. The members of NEC and the Management Communication Meeting review the project

4. If a leader determines that their department is a stakeholder in the project, they contact the team leader.
5. Once all the stakeholders are identified, the team leader will continue planning the project using the appropriate Performance Improvement methodology.

The standardized form is available in Appendix E.

Baseline data and current evidence demonstrated the need to have a standardized approach to improvement projects that engages the appropriate stakeholders. In response to this data, the interventions were designed. In the absence of an improvement project to trial the interventions, online learning modules were created that describe the new standardized process and Magnet© data collection standards. Creating an electronic module ensures that the information will always be accessible for review to anyone conducing an improvement project. Many leaders have expressed their desire to implement this process when the leadership changes have been completed and improvement projects resume. Therefore, the online educational models were created to ensure that health system leaders, project leaders, and project participants will have easy access to the tools and information needed to follow this process for improvement projects.

GAP analysis. A gap analysis was performed and showed that there was not a standard way to plan, implement, and measure improvement projects. Also, many project leaders and staff members were not aware of the Magnet© standards for data collection; the resulting outcome of this lack of knowledge were that projects that were successful could not be utilized as a "story" in the Magnet© designation document.

This lack of adherence to consistent processes for quality improvement projects was a deviation from the literature because it is clear that having a standardized process in place is essential to the success of the project. It is also essential that Magnet© designated facilities follow proper data collection methods at all times. The complete gap analysis is available in Appendix F.

GANTT. The project was conducted from November 2016 to January 2018. The project GANTT chart is available in Appendix G. The adjusted timeline due to the challenges of implementing the original project included:

- November 2016: identify gap
- December 2016: meet with CNO to explain gap analysis and obtain permission to move forward
- December 2016 to February 2017: literature review
- March to May 2017 complete project prospectus
- March 2017: meet with CNO to present project prospectus and obtain letter of support. Also, present project prospectus to NEC
- March 2017 to November 2017: design interventions with input from Health System leadership (standardized process)
- June-September 2017: create educational module about Magnet© data collection standards
- December 2017: create online educational modules
- January 2018: distribute educational modules and obtain feedback.

The first step was to complete a gap analysis of the current state to form a PICO question. Once the PICO question was created a literature search and review was completed in order to identify best practices regarding the standardization of improvement projects and maintaining Magnet© standards. The next step was identifying the various committees and meetings in order to create the most effective way to coordinate and collaborate amongst all leaders without adding any additional meetings. Next, the standardized process and the educational toolkit regarding Magnet© data collection standards were created. When it was determined that no improvement projects were going to be conducted during the implementation timeframe for the DNP project, the online educational module for the standardized process for conducting improvement projects was developed and implemented.

SWOT analysis. Again, due to the administrative challenges the initial SWOT analysis of the project's strengths, weaknesses, opportunities, and threats was performed so that the challenges could be mitigated effectively. Due to the challenges, the SWOT analysis was amended and included:

Strengths. The strengths of the project included a strong governance structure, and being a Magnet© facility

Weaknesses. The weaknesses for this project included the complete re-design of the health system leadership structure, perceived lack of interest in change, lack of knowledge about gap in best practices, and conflicting organizational priorities (due to transformation and integration).

Opportunities. The opportunities for this project included the chance to collaborate with other Magnet© designated facilities that currently utilize the Iowa

Model and the potential of improving quality improvement project processes across both facilities

Threats. The threats to the project included being reliant on ANCC standards for data collection which can cause delays, and additional requirements that may occur from ANCC in the near future that will impact the ways in which quality improvement activities should be performed.

A table of the SWOT analysis is available in Appendix H.

The root cause of the knowledge deficit regarding the need for a standardized process was in part due to the siloed work created by the current processes and the lack of involvement by the proper stakeholders. These barriers were mitigated by respectfully explaining the challenges using specific examples and lessons learned from previous improvement projects.

The most significant barrier to the implementation of the process was the sudden change in health system's transformation and integration initiatives. Due to these changes, there were no improvement projects being conducted throughout the organization and there was disruption to normal hospital operations due to the leadership changes. Many health system leaders' responsibilities changed, so it was unclear who would be responsible for any projects that would have been initiated. Creating the educational modules mitigated this challenge so that the organization has access to the material when it has reached a state of transformation that will support continuous improvement projects.

Project budget. The project budget was approximately $16,000. The costs involved meeting time, food, and other unexpected incidentals. The project took

approximately 20 hours of meeting time with various nursing leaders for six months at $50 per hour, for a meeting cost of $6,000. The DNP student provided over 150 hours with an approximate cost of $7,500. There was a cost of approximately $1,000 for food and $1,500 for incidentals and supplies were also budgeted. The budget breakdown is available in Appendix I.

Return on investment. Based on redundant work and meeting time, it was estimated that the siloed and unstandardized process costs the organization $54,000 in potential duplicate work each year. It is estimated that based on the more efficient methods in the new processes, the health system would be able to eliminate 90 meeting hours per month (15 hours per month for 6 individuals) at a cost of $50 per hour: 90 hours at $50 is $4,500 per month and equals $54,000 per year. Based on these estimates, the project would break even after four months. After the initial costs of $16,000 to develop and implement the project it is projected to cost approximately $2,250 per year to maintain. Those costs would include meeting time, and health system leaders' time to review a proposed project that is presented to them. So in an average year there were be a potential cost savings/avoidance of $51,750 per year. These savings could be utilized to provide additional part-time administrative support in coordinating quality improvement projects for the organization due to the cost of additional administrative staff would be approximately $50,000 per year (benefited).

Responsibility and work breakdown structure

The human resources that were necessary to implement this project were representatives from: senior leadership, nursing, quality, ancillary departments, and nursing education. Meetings were held to discuss and plan the project with the CNO,

other nursing leaders, and nursing education. The DNP project manager (also the student) was responsible for providing evidence to the team, facilitation the work of the team, and providing project implementation and evaluation. The CNO was responsible for providing oversight and project support. The elements of the work breakdown structure are in Appendix J.

Communication

An initial meeting was held with the CNO in order to present the: problem, justification, literature review, and project plan. Once the project was approved by the CNO, the project manager (DNP student) designed the standard process and then presented the plan to the Nurse Executive Council. E-mail was used to communicate with the CNO, nursing education, and other nursing leaders during the course of the project. The DNP student also created the online learning modules in PowerPoint and then recorded the module and the Magnet© toolkit. The individual responsible for creating and maintaining the knowledge center module put the recorded Power Point into the Knowledge Center platform. The communication matrix is displayed in Appendix K.

Measures and study of the intervention

A baseline survey was conducted of hospital leaders and nursing council members regarding their thoughts and opinions about the current state of the organization as it pertained to quality improvement activities. Based on the feedback that was received, a toolkit with important information was developed and evaluated by key stakeholders such as the Magnet© Program Director, Nursing leaders, and past project leaders. Due to the challenge of being unable to implement and evaluate the toolkit due to the moratorium on quality improvement projects at the organization, it was decided that it would be helpful

to convert the toolkit into an online module through the Health Stream platform. Working with the instructional design specialty, the toolkit was successfully developed on the platform.

Key stakeholders were utilized to review the developed module through the Health Stream platform as a means to ensure that the information was clear to the end user and to assess whether the users would utilize the information in the future for projects. Questions assessed how likely the participant would be to implement the process in the future when performance improvement projects resume. Survey Monkey was utilized to survey end users. The questions used a Likert scale to rate their satisfaction with the module and the new standardized process. It also asked the end users to rate the likelihood that they would implement this process in the future.

Qualitative data was also obtained from nursing leaders, nursing council members, and others that were involved in improvement projects through informal conversations about the new standardized process that was created; the results of these conversations were that nursing leaders support the interventions and would like to see them implemented at John Muir Health. A nursing leader stated, “this is a great idea, it’s very organized, and I know our project leaders are hungry for this type of structure.”

It was suggested that when a quality improvement project is implemented in the future, participant satisfaction with the project should be measured. Participant satisfaction could be measured using the same questions that were asked of previous project participants to obtain pre-implementation data.

Ethical considerations

The University of San Francisco determined this project was an evidence-based change of practice project. The Non-Research determination form is in Appendix L. Patients were not involved in this project, therefore no patient medical records we accessed. No conflicts of interest were identified.

The project follows the American Nurse's Association's (ANA) code of ethical principle beneficence defined as "compassion; taking positive action to help others; desire to do good; core principle of our patient advocacy" (Beauchamp and Childress, 2009 p 38-39). The project was an example of this principle because it was advocating for patient outcomes by addressing the way performance improvement projects are conducted. The project also follows provisions 4, 6, and 7 from the ANA Code of Ethics. Provision 4 states that "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care" (ANA, 2015 p 15). Provision 6 states that "The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care" (ANA, 2015 p 23). Provision 7 states "The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy" (ANA, 2015 p 27). These standards align with the intent of this project as it supports the need for advancing the profession.

The project also aligns with the Jesuit value of Women and Men for others and University of San Francisco's value of "change the world from here" because all quality

improvement projects are done to improve quality for the patients we care for. In addition to continually striving to improve the quality of care for patients, it is also important for healthcare systems to be good stewards of their resources in order to continue providing affordable health care to our communities.

Section IV-Results

The educational module that described the new standardized process was distributed to various nursing councils and the Professional Development Specialists (formerly Nursing Educators). The nursing councils were involved because it is a vital part of the Magnet© shared governance structure that. Feedback from the Professional Development Specialist was obtained because they support most projects and serve as a facilitator between the project leaders and hospital leadership. The Magnet© Program Director evaluated the educational module.

Approximately 40 surveys were distributed and nine were returned that evaluated satisfaction and likeliness of using this process in the future. The results indicated that the respondents believe this process would be valuable to John Muir Health and would like to see the process implemented with subsequent projects.

The results to the questions “this process would be beneficial to JMH” showed that 89% (n=8) answered “5” indicating that they completely agree with the statement. When asked the question “I would like to see this process implemented at JMH” 22% (n=2) answered “4” and 78% (n=7) answered “5”. Graphs displaying the results are provided in Appendix M and the PowerPoint slides included in the Knowledge Center modules are displayed in Appendix N.

Section V- Discussion

Summary

The literature review was insightful about best practices and answered the PICO question that asked whether in Acute care hospitals, how does a standardized approach to quality improvement projects, compared to a non-standardized approach, affect quality care and patient safety? The literature was clear that thoughtful planning and stakeholder engagement was critical to a project's success, however most studies utilized their own approach instead of a proven evidence-based model. The Iowa Model of Evidence-Based Practice to Promote Quality Care is an established process that has proven to be effective in the few projects that utilized it. While most of the articles reviewed describe their approach to specific improvement projects, there was no mention of a standardized approach for all projects. It was also clear that Magnet© designation standards require an evidence-based approach. The nursing profession has an opportunity to impact and improve quality care and decrease costs. However, there was a lack of evidence that describes the best practice for how to approach and design quality improvement projects. The best practices for planning improvement projects have not been identified in the literature.

The pre-implementation data that was obtained had great variability in participant satisfaction, which was indicative of the non- standardized process. Survey results measuring the satisfaction of the new process suggest that the interventions would be beneficial to John Muir Health and will likely be implemented in the future.

The DNP student's recommendation for John Muir Health is to implement the standardized process that were created when Quality/Performance Improvement projects

resume. Once the transformation and integration initiatives are complete, the DNP student will continue to present the project and further aide with the implementation utilizing an actual quality improvement project.

Interpretation

Based on the data collected, it can be assumed that the interventions will be beneficial to John Muir Health. In addition to the data, the designed interventions are in line with the most current literature about the design of improvement projects. The impact on the healthcare system leadership will be a small amount of work to review proposed projects that are presented to them. Despite the small amount of additional work to review projects, it will cause greater stakeholder engagement and participation. Ultimately having increased stakeholder participation will benefit the organization by being able to fully capitalize on the cost avoidance or decreased costs associated with the improvement project. Also improving participant satisfaction will produce better results and increased interested in participating in improvement projects.

Limitations

The literature review was limited by the lack of evidence about how to approach improvement projects in conjunction with Magnet standards©. Not only was there very little evidence, the quality of the evidence was only levels III-IV based on the Johns Hopkins Evidence Appraisal tools. The literature search was also limited to articles that were available through the University of San Francisco library databases.

Another limitation to the project was the inability to implement the proposed changes. Due to significant changes to hospital leadership that have been described earlier in this manuscript, which caused all initiatives to be on hold therefore there was

not a quality/performance improvement project being conducted at the time of this DNP project to be able to implement and evaluate the proposed processes. The leadership changes also caused chaos and stress among all staff members, so this DNP project was not a priority. Due to being unable to implement the initial proposed interventions outlined in the prospectus, the concepts were converted into online educational modules so that John Muir Health has access to the resources required to implement the changes in the future.

Another limitation to the project was the small number of survey responses in the review of the modules. There was a total of 20 surveys distributed for the pre-implementation survey with seven respondents (42 %). There was a total of 40 surveys distributed for the feedback on the education modules with 9 respondents (25%). Even though the number of surveys distributed and received back is small, only a subset of the entire healthcare system was surveyed, based on participation in improvement projects as those were the targeted audience for this project.

Conclusions

Magnet© designated facilities should utilize available evidence-based tools for conducting quality improvement projects. The lack of available literature on this topic provides an opportunity for the nursing profession at John Muir Health to contribute to the field of knowledge by identifying the best practices regarding planning improvement projects and publishing their results.

By using the available tools and continually seeking out the best evidence and implementing it in our healthcare systems, we will be able to continuously decrease cost and improve the quality of care provided to our patients.

Adopting the newly created standardized process for improvement projects that allows all stakeholders to be engaged from the beginning is just one way that we can adapt to changes in health care reimbursement models. By ensuring that the team is complete and has the support necessary to make changes, John Muir Health can continue it's transformational journey and ensure that we are able to meet the needs of our community and patients.

References

Agency for healthcare research and quality (2017). Toolkit for using the AHRQ quality indicators. AHRQ.gov

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements.* Washington, DC.

Bakker, D. & Keithley, J. (2013). Implementing a centralized nurse-sensitive indicator management in a community hospital. *Journal of nursing quality (28) 3* 241-249. DOI 10.1097/NQC.ob013e31827c6c80.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed., pp. 38-39). New York, NY: Oxford University Press.

Bokhoven, M., Kok, G. & Weijden, T. (2003). Designing a quality improvement intervention: a systematic approach. *BMJ of quality and safety. (12)* 215-220.

Bolton, L. & Goodenough, A. (2003). A Magnet nursing service approach to nursing's role in quality improvement. *Nursing administration quarterly (27) 4* 344-354

Brockman, V. (2015). Implementing the mother-baby model of nursing care using models and quality improvement tools. *Nursing for women's health (19) 6* 490-503. DOI: 10.1111/1751-486x.12245.

Burnes, L. & Goodenough, A. (2003). A Magnet nursing service approach to nursing's role in quality improvement. *Nursing Administration Quarterly 27(4)* 344-354.

Czabanowska, K., Klemenc-Ketis, Z., Potter, A., Rochfort., A., Tomasik, T., Csiszar, J. & Den Bussche, P. (2012). Development of a competency framework for quality improvement in family medicine: a quantitative study. *Journal of continuing education in the health professions. (32) 2* 174-180.

Goeschel, C., Weiss, W. and Pronovost, P. (2012). Using a logic model to design and evaluate quality and patient safety improvement programs. *Journal for Quality in Healthcare 24(4),* 330-337.

Johns Hopkins Hospital/The Johns Hopkins University (2012). Non-research appraisal tool. In S. L. Dearholt & D. Dang. (Eds.). *Johns Hopkins nursing evidence-based practice: Model and guidelines* (2nd ed., pp. 241-244). Indianapolis, IN: Sigma Theta Tau International Honor Society of Nursing.

Kotter, J. (1996). Kotter's 8 step process for leading change. Retrieved from kotterinternational.com

Kubiak, T.M. and Benbow, D.W. (2009) The Certified Six Sigma Black Belt Handbook. ASQ Quality Press, Milwaukee

Lovlien, C., Johansen, M., Timm, S., Eversman, S., Gusa, D. & Twedell, D. (2007). Improving program documentation quality through the application of continuous improvement processes. *The journal of continuing education in nursing. (38) 6* 271-276

Mantinheikki, J., Artto, K., Peltokorpi, A. & Rajala, R. (2016). Managing inter-organizational networks for value creation in the front-end projects. *International journal of project management (34) 2016* 1226-1241. DOI: 10.1016/j.ijproman.2016.06.003.

Murphy, B. (2013). Mobility/activity circles: a quality improvement effort to reduce falls. *Medsurg nursing (22) 6* 365-369

Reed, J., McNicholas, C., Woodcock, T., Issen. & Bell, D. (2014). Designing quality

improvement initiatives: the action of effect method, a structured approach to identifying and articulating programme theory. *BMJ quality and safety (23)* 1040-1048. DOI: 10.1136/bmjqs-2014-003103.

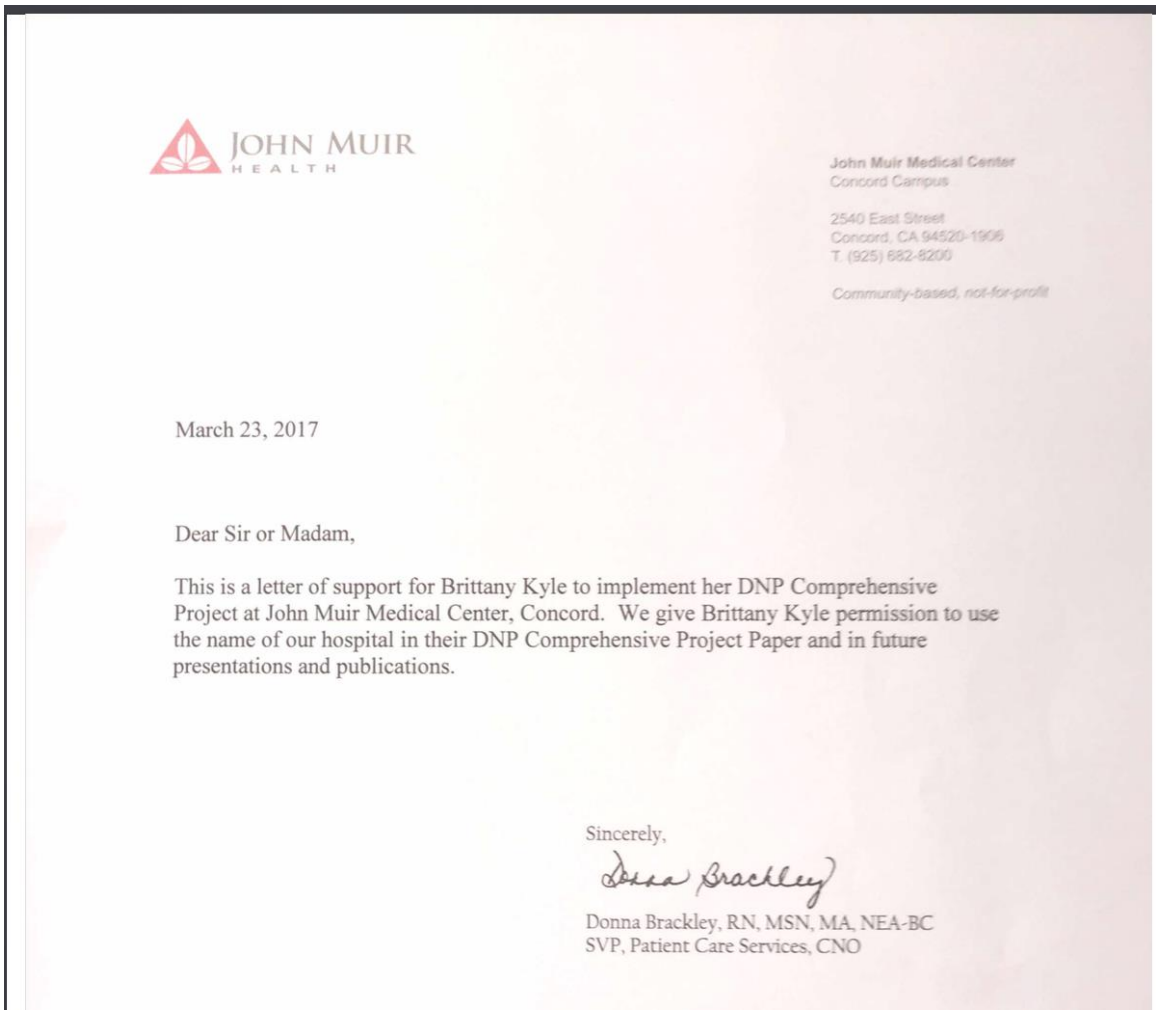
Smith, A. (2007). Paving and resurfacing the road to Magnet: Part III—unique and organizational characteristics. *Medsurg nursing (16)1* 35-37.

Strating, M., Nieboer, A., Zuiderent-Jerak, T. & Bal, R. (2011). Creating effective quality-improvement collaborative: a multiple case study. *BMJ of quality and safety (20)* 344-350. DOI: 10.1136/bmjqs.2010.047159.

Taylor, N. (2009). The magnetic pull. *Nursing Management 36(4),* 48-58.

Appendix A

Letter of Approval



JOHN MUIR HEALTH

John Muir Medical Center
Concord Campus

2540 East Street
Concord, CA 94520-1906
T. (925) 682-8200

Community-based, not-for-profit

March 23, 2017

Dear Sir or Madam,

This is a letter of support for Brittany Kyle to implement her DNP Comprehensive Project at John Muir Medical Center, Concord. We give Brittany Kyle permission to use the name of our hospital in their DNP Comprehensive Project Paper and in future presentations and publications.

Sincerely,

Donna Brackley

Donna Brackley, RN, MSN, MA, NEA-BC
SVP, Patient Care Services, CNO

Appendix B

Evidence Evaluation Table

Author/Year	Study Design	Setting	Sample	Evidence Level	Outcomes
Bakker and Keithly (2013)	Non-experimental study	Magnet® designated facility in Western Michigan	Entire hospital	III B	57 Nurse Sensitive Indicators were identified- an 81% increase.
Bokhoven, Kok, and Weijden (2003)	Non-experimental study	Not described	Entire health system	III B	Systematically mapping interventions is an effective method for performance improvement
Bolton and Goodenough (2003)	Case Study	Cedars Sinai Health System, Los Angeles, California	Entire hospital	V A	Drop in restraint use from 4.5% to 2.5% 98% of identification of patients with allergies Decreased use of seclusion and restraints on the psychiatric unit Decreased length of stay on stroke rehab unit from 14.5 (regional average is 18 days)
Brockman (2016)	Non-experimental study	495 bed urban hospital in the South West United States	Labor and delivery unit, post partum unit, and newborn nursery	III B	Successful integration of all units to support the mother-baby model. 36% increase in breastfeeding rates, 98% patient satisfaction, and 100% productivity
Burke (2005)	Case study	Miriam Hospital, Providence Rhode Island	Entire hospital	V A	All employees and leaders must understand Magnet® standards and work to ensure it is part of the organization's culture
Corn (2009)	Expert opinion	n/a	n/a	V B	Use of Six Sigma in health care
Czabanowska et al. (2012)	Non-experimental study	European Association for Quality in General Practice Invitational	Not described	III B	55 competencies for performance improvement were defined and organized into 6 domains: Patient Care and Safety, Equity

		Conference			& Ethical Practice, Methods & Tools, Continuing Professional Development, and Leadership & Management
Goeschel, Weiss, and Provonost (2012)	Non-experimental study	Michigan	130 ICUs	III B	Use of the Logical Theory to design a Comprehensive Unit-Based Safety Program and 66% reduction in CLABSI rates
Gomes and Romao (2016)	Case Study	Not described	Not described	V B	Use of the Benefits Management approach can motivate staff and achieve compliance from stakeholders
Lovlien et al. (2007)	Case Study	Mid-Western Hospital	Department of Nursing Education and Professional Development Division	V A	Development of audit tool to identify expectations of educational programs—27% improvement in accuracy
McAlearney (2008)	Qualitative Literature Review	Not described	3 studies about leadership development	V B	Themes: Improving the Caliber and Quality of the Workforce, Improving efficiency in education and development, reducing turnover and related expenses, and Focusing organizational attention in priorities of improved quality and efficiency
Mantinheikki, Artto, Peltokorpi, and Rajala (2016)	Expert Opinion	n/a	n/a	V A	Managers should focus on non-project related team building. Identified 5 value creating attributes: centrality of leading actor, network density, tie strength, trust, and shared vision.
Murphy (2013)	Non-experimental	Medical/Renal Unit	Not described	III B	67% decrease in fall rates over 3 months

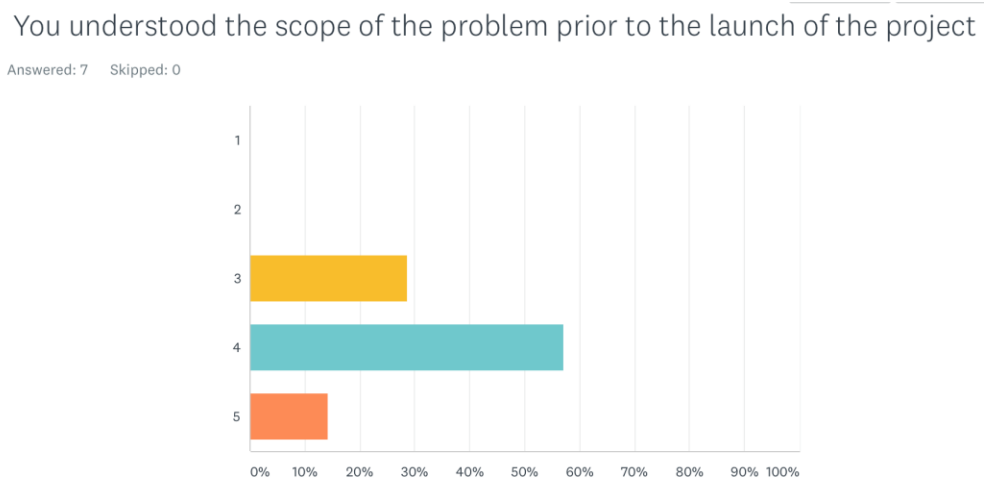
	study				
Provonost et al. (2009)	Expert Opinion	n/a	n/a	V A	Recommendations to create structure for quality improvement in health care
Reed, McNichols, Woodcock, Issen, and Bell (2014)	Case Study	Not described	National Institute for Health Research Collaboration for Leadership in Applied Health Research and care, Northwest London	V A	Use of Action Effect Model to develop programme theory
Smith (2007)	Expert Opinion	n/a	n/a	V B	Description of the Magnet® journey
Strating, Nieboer, Zuiderent-Jerak, and Bal (2011)	Case Study	182 teams from organizational development improvement initiatives	Not described	V A	Significant difference in measurement and achievement of goals
Taylor (2005)	Expert Opinion	St. Cloud Hospital, St. Cloud Minnesota	Entire hospital	V B	Description of Magnet® journey

Appendix C

Pre-Implementation Data

The questions asked the participants to rate their satisfaction with the following statements, 1= completely disagree and 5= completely agree:

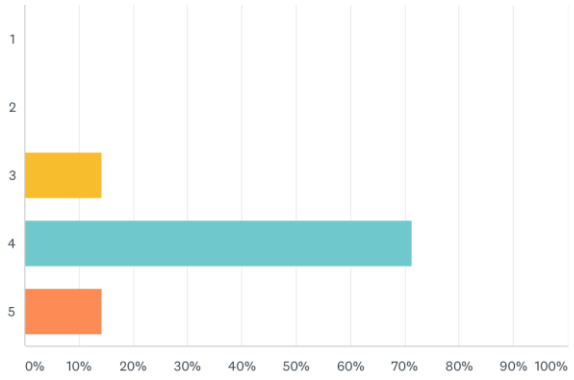
1. You understood the scope of the problem prior to the launch of the project
2. You understood the scope of the project prior to the start of the project
3. The group was able to identify the root cause(s) of the problem
4. The group was able to identify a solution(s) to the problem
5. The team members were appropriate for the project/problem
6. There was leadership/organizational support for the project
7. The team had adequate resources to implement the proposed solutions
8. Processes were put into place to measure the success of the project/solutions over time.



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	28.57%	2
4	57.14%	4
5	14.29%	1
TOTAL		7

You understood the scope of the project prior to the start of the project

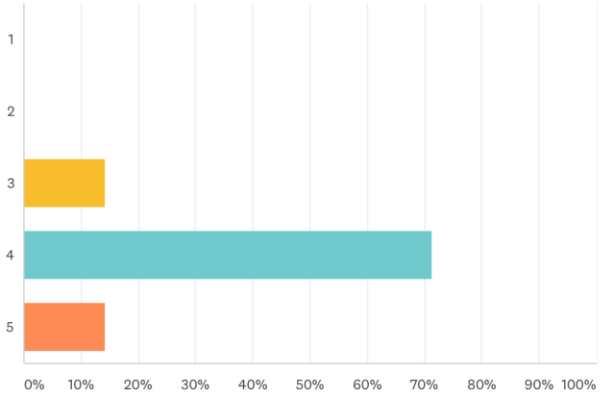
Answered: 7 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	14.29%	1
4	71.43%	5
5	14.29%	1
TOTAL		7

The group was able to identify the root cause(s) of the problem

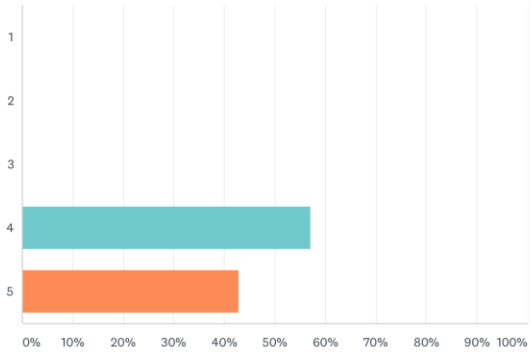
Answered: 7 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	14.29%	1
4	71.43%	5
5	14.29%	1
TOTAL		7

The group was able to identify a solution(s) to the problem

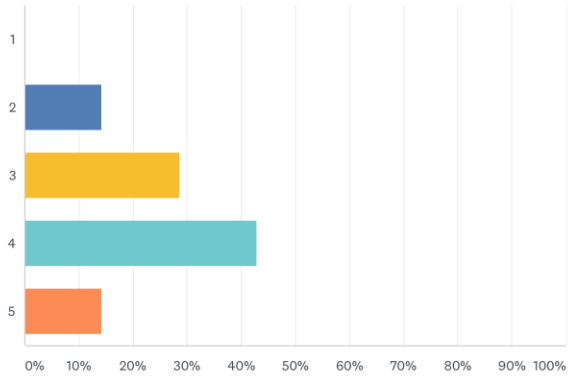
Answered: 7 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	0.00%	0
4	57.14%	4
5	42.86%	3
TOTAL		7

The team members were appropriate for the problem/project

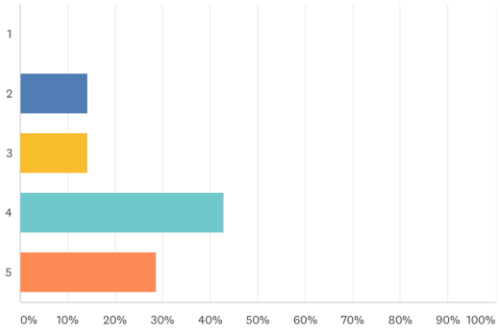
Answered: 7 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	14.29%	1
3	28.57%	2
4	42.86%	3
5	14.29%	1
TOTAL		7

There was leadership/organization support for the project throughout the process

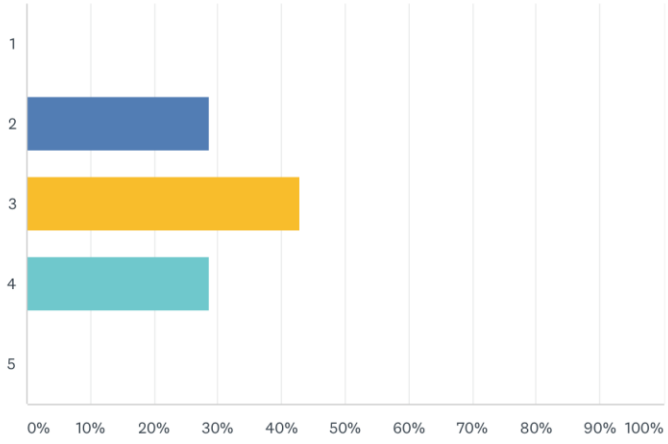
Answered: 7 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	14.29%	1
3	14.29%	1
4	42.86%	3
5	28.57%	2
TOTAL		7

The team had adequate resources to implement the proposed solutions

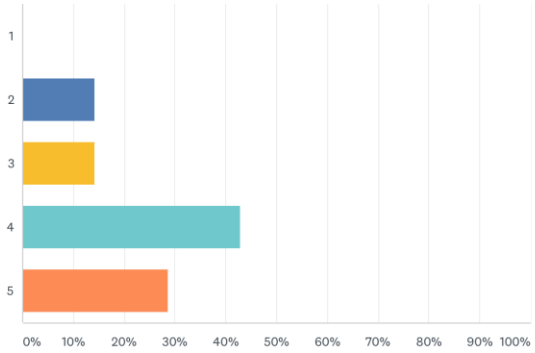
Answered: 7 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	28.57%	2
3	42.86%	3
4	28.57%	2
5	0.00%	0
TOTAL		7

There was leadership/organization support for the project throughout the process

Answered: 7 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	14.29%	1
3	14.29%	1
4	42.86%	3
5	28.57%	2
TOTAL		7

Appendix D

Conceptual Framework
The Logical Model

(Goetschel et al., 2012)

Kotter's Change Theory

(Kotter, 1996)

Appendix E

Submission Form; adapted from the Iowa Model

Description of problem:

Trigger:

___Risk Management
___ Process Improvement
___Internal/External Benchmarking Data
___ Identification of Clinical Problem
___New Research/literature
___National Agencies/Organizational Standards & Guidelines
___Philosophies of Care
___ Questions from Institutional Standards Committee

Is this an organization priority?

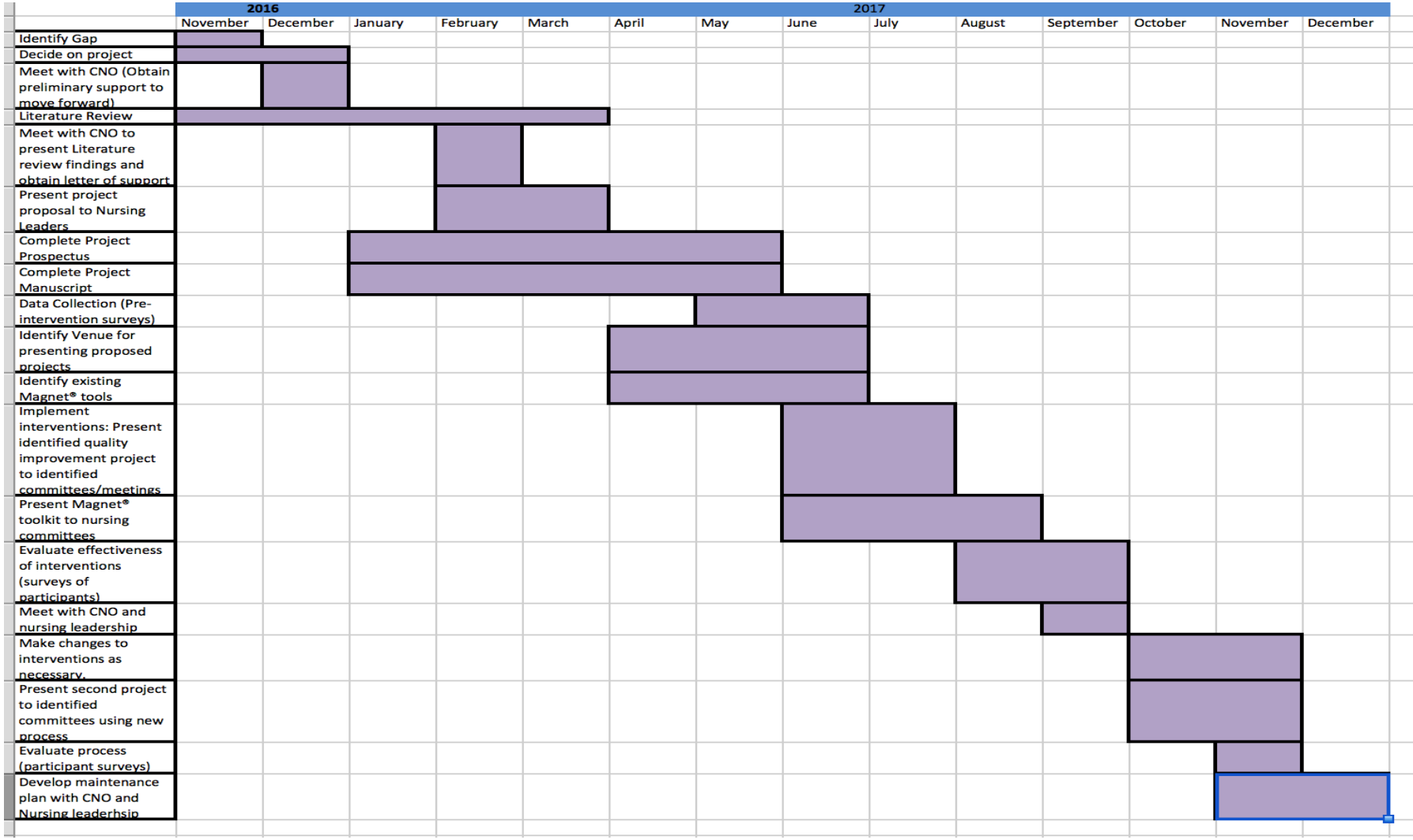
Contact:

Appendix F
Gap Analysis

Best practice	Current Practice	Recommendation
Use standardized process to engage stakeholder in improvement projects	Performance improvement methodology is uses, but there is no standardized process that allows all stakeholders to be engaged from the beginning	Create a standardized process which will also all necessary stakeholders to be engaged from the beginning of the project
Adhere to Magnet© data collection standards at all times	Many project leaders are not aware of the data collection standards. Therefore data collection is not done consistent with Magnet© standards	Create toolkit for Magnet data collection standards, so that standards are met at all times

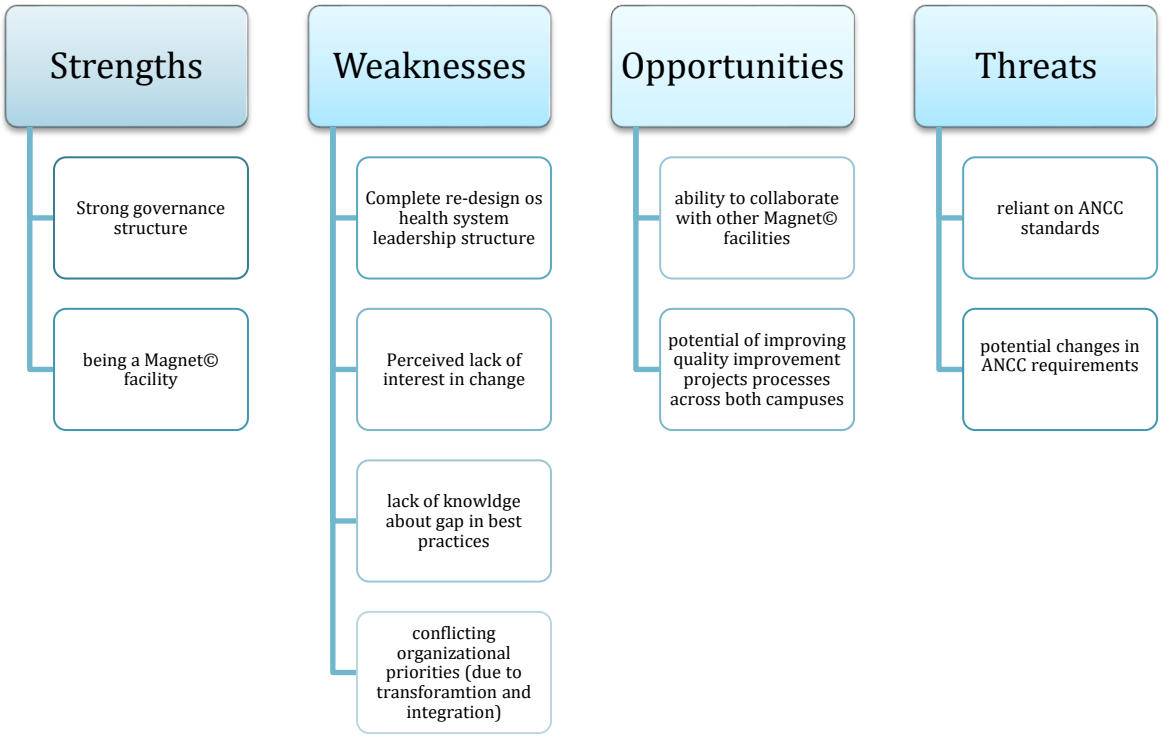
Appendix G

GANTT chart



Appendix H

SWOT Analysis



Appendix I

Budget and Return on Investment

20 hours of meting time/month @$50/hr= $1000 x 6 months = **$6,000**

- 8 hours with CNO
- 10 hours to develop Magnet® Toolkit
- 2 hours with Nursing Education

150 hours of work for DNP Project Manager @ $50/hr = **$7,500**

- Data collection
- Literature review
- Meeting with CNO, Administrative Assistant, Nursing Education, and Nursing Councils
- Implementation of interventions

Food: **$1,000**

Unexpected incidentals: **$1,500**

Total: $16,000

Potential return on investment:
6 month post implementation: elimination of 15 hours of redundant meetings with 6 participants each= 90 meeting hours at $50/hr= $4,500 savings per month.

Break even in 4 months.

Cost beginning year 2
15 people review each project @$50/hrs. for 3 projects per year= 15x15x3= **$2,250 per year**

Potential Return on Investment

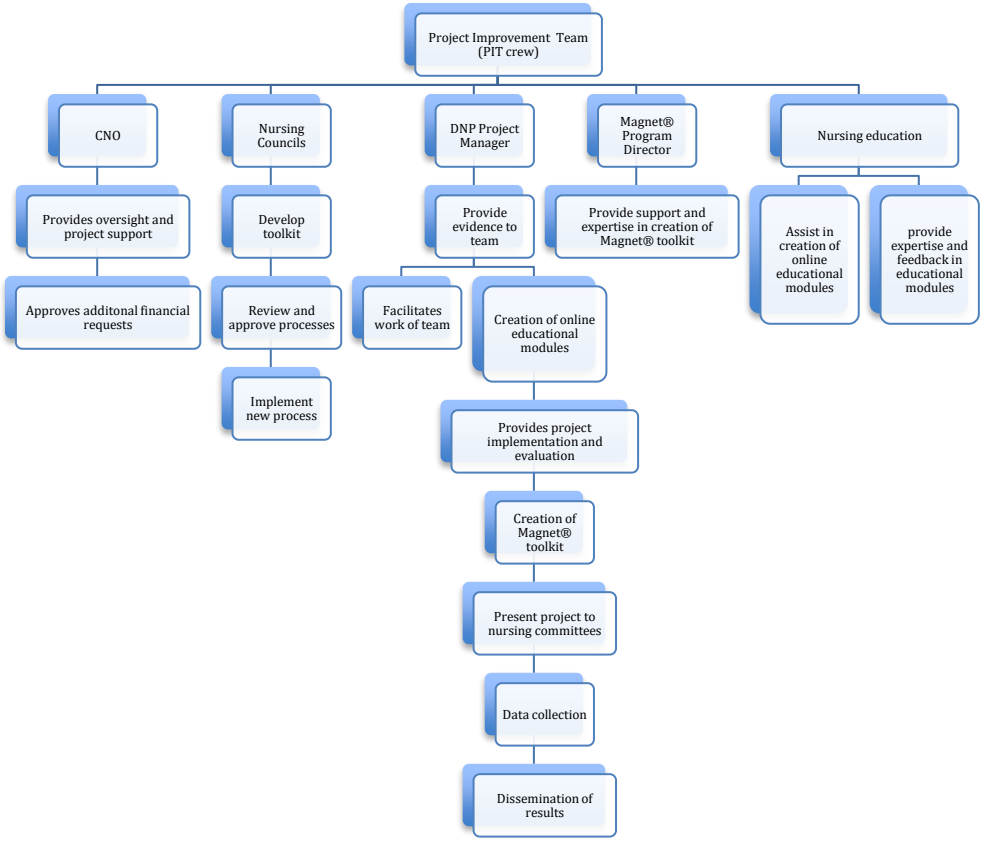
- Elimination of 15 hours of redundant meetings with 6 participants each = 90 meeting hours at $50/hr= **$4,500** savings per month = **$54,000 per year**
- Elimination of 50 hours/ year spent on writing Magnet ® Re-designation Document @ $50/hr= **$2,500** savings per year.

Total savings per year: $ 51,750

($56,5000-$2,500)

Appendix J

Work Break Down Structure



Appendix K

Responsibility and Communication Matrix

Name	Role	Responsibility	Communication method
DNP student	Project manager	Perform literature review, identify gap in current practice, collaborate with hospital leaders to develop standardized process and Magnet© toolkit	In person meetings and e-mail
CNO	Support and collaboration	Provide support and approval for project	2 in person meetings and e-mail
Nurse executive council	Support and collaboration. Leadership piece of shared governance	Provide approval and support for process	1 in person meeting
Magnet© program director	Collaborate on Magnet© toolkit	Provide guidance and approval for Magnet© data collection standards	1 in person meeting, then e-mail
Nursing Council	Magnet© shared governance	Collaboration on standardized process and Magnet© toolkit	In person presentation and e-e- mail

Appendix L
DNP Statement of Non-Research Determination Form

Student Name: Brittany E. Kyle

Title of Project: Magnetizing Project Improvement Program Processes

Brief Description of Project:

The intention of the project is to create a standardized way to assign, approach, and communicate hospital wide improvement projects to ensure that Magnet standards are followed. Magnet standards are deigned to promote quality nursing care and positive patient outcomes (Taylor, 2005). Using the cross walk created by Lyle-Edrosolo and Waxman (2016) as a guide, quality and Magnet standards can be achieved when conducting improvement projects. The Logical framework approach that relies on backward planning will also be used. The first step is identifying the goal, then the team works backward when planning a project. The next steps are identifying Results, Objectives, Outputs, Activities, and Inputs (Goeschel, Weiss, & Pronovost, 2012).

A) Aim Statement: By December 2017, assess, develop, implement, and evaluate a standardized way to assign, implement, and manage improvement projects at a Magnet facility.

B) Description of Intervention:

- Create standard processes to assign, implement, and manage improvement projects. By creating tools utilizing a team of organizational leaders from all departments to review requests and to approve improvement projects based on organizational goals and priorities. Having leaders from all departments will ensure that the appropriate stakeholders are involved in the planning and implementation of the improvement project. An article by Taylor (2009) describes a standardized way to post proposed projects and allows staff members who are interested to volunteer to participate.

- As part of the project utilization of Magnet standards to ensure consistency with projects within the system. This will be provided in collaboration with the Director of Professional Practice/Magnet Program Director. Currently, many of the people running improvement projects are not familiar with the Magnet standards; this causes increased work upon project completion to collect additional/different data or the failure to meet Magnet standards at all.

- Provide Lean and Six Sigma training to Unit Council members so that all improvement projects on the unit level can follow the Lean and Six Sigma methodologies. This is how hospital wide project are conducted and is a goal of the Chief Nursing Officer to be performed at the unit level. Taylor (2009) describes the traditional plan-do-study-act process as an effective method to manage and track improvement projects process and outcomes.

C) How will this intervention change practice?

This will change the way projects are assigned, managed, and evaluated. Magnet standards will be followed with every projects and duplicate work will be eliminated. This will allow project goals and deliverables to be achievable which will yield a better return on investment, improved patient outcomes, and increased nursing satisfaction with improvement projects.

For example: a previous improvement project was conducted to standardize patient handoff. This project was brought to a Performance Improvement Leader (non-clinical) from a non- clinical committee that addresses safety in the health system. Nurses are a key stakeholder in this initiative but were not included in the development of goals and deliverables. This resulted in conflicting expectations and ultimately no change was made. This caused nurses that participated to be disappointed and dissatisfied with the outcome. The time, money, and resources that were devoted to this initiative were essentially wasted. With the proposed changes, all leaders from Nursing, Safety, and Quality (Performance improvement) would have been involved from the beginning of the project so goals and deliverables would be mutually set and agreed upon.

D) Outcome measurements:

- Assess satisfaction of leadership team throughout process as a new form and processes are developed and implemented.

- Utilizing the Magnet self –assessment checklist provided by ANCC for ensuring projects are done according to Magnet standards. Team leaders will have access to this checklist and will perform the self assessment at the completion of the project. 100% compliance will be the expectation by December 2017.

- Achievement of project goals. Upon completion of the improvement project the team will be able to measure the achievement of project goals. Expectation that whatever the goals are for a particular project, 80% of the

goals are obtained by December 2017 of the identified project.

References

Goeschel, C., Weiss, W. and Pronovost, P. (2012). Using a logic model to design and evaluate quality and patient safety improvement programs. *Journal for Quality in Healthcare 24(4),* 330-337.

Lyle-Edrosolo, G. & Waxman, K.T. (2016). Aligning heathcare safety and quality competencies: quality and safety education for nurses (QSEN), The Joint Commission, and the American Nurses Credentialing Center (ANCC) Magnet standards crosswalk. *Nurse leader 14(1),* 70-75.

Taylor, N. (2009). The magnetic pull. *Nursing Management 36(4),* 48-58.

Appendix M

Post Module Implementation Survey

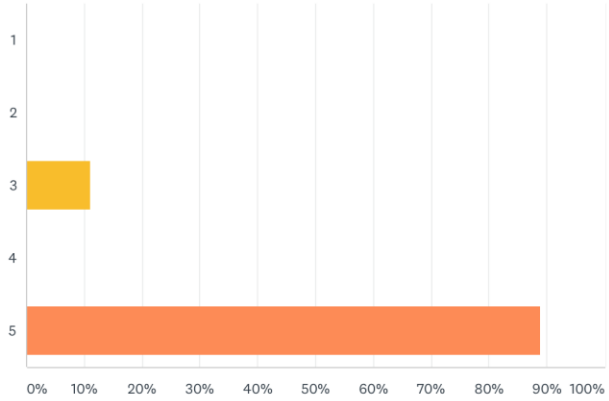
Survey questions:

The survey questions asked participants to rank their agreement with the following statements, 1=completely disagree and 5= completely agree:

1. This process would be beneficial to John Muir Health (JMH)
2. The standardized process described in this module is clear and easy to follow
3. The module matched the deliverables
4. I would like to see this process implemented at JMH
5. The requirements for data collection are clear
6. The Iowa Model is an appropriate tool to use for this process

This process would be beneficial to JMH

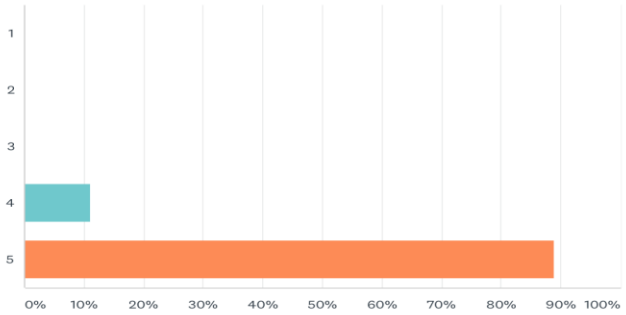
Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	11.11%	1
4	0.00%	0
5	88.89%	8
TOTAL		9

The standardized process described in this module is clear and easy to follow

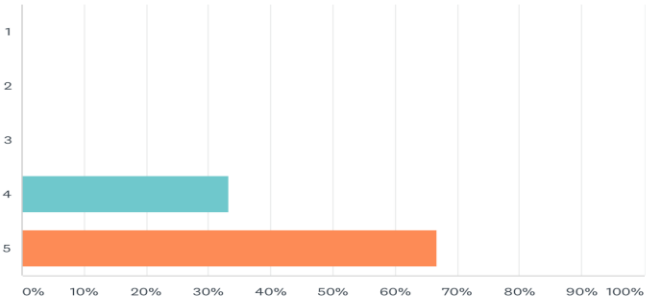
Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	0.00%	0
4	11.11%	1
5	88.89%	8
TOTAL		9

This module matched the deliverables

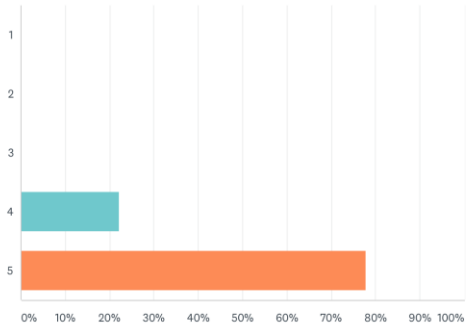
Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	0.00%	0
4	33.33%	3
5	66.67%	6
TOTAL		9

I would like to see this process implemented at JMH

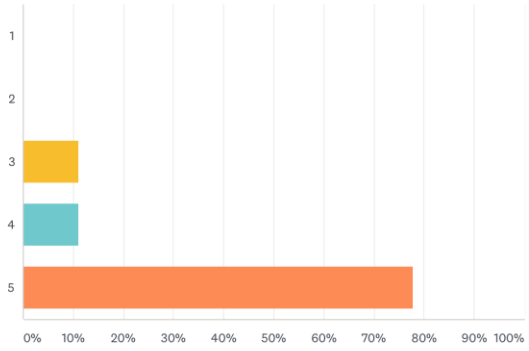
Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	0.00%	0
4	22.22%	2
5	77.78%	7
TOTAL		9

The requirements for data collection are clear

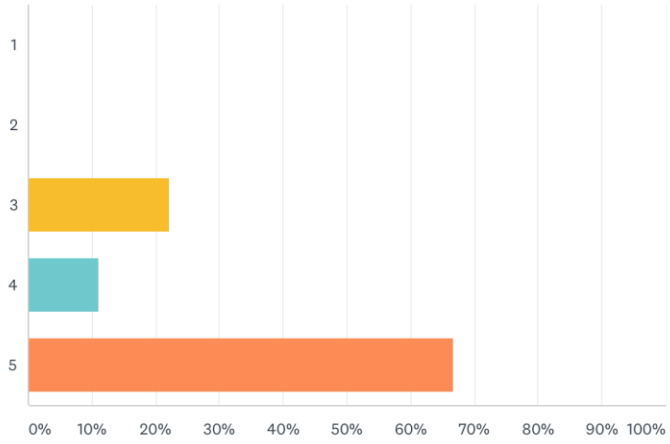
Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	11.11%	1
4	11.11%	1
5	77.78%	7
TOTAL		9

The Iowa Model is an appropriate tool to use for this process

Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
1	0.00%	0
2	0.00%	0
3	22.22%	2
4	11.11%	1
5	66.67%	6
TOTAL		9

Appendix N
PowerPoints Developed for Educational Module

Standardizing and Magnetizing Improvement Projects

Objectives

After completion of the module the learner will be able to describe:

- The benefits of having a standardized process for improvement projects
- The steps of a standardized process
- The use of the Iowa© Model during improvement projects
- The process of data collection to meet Magnet© standards

Process Overview

1. Create standardized process for improvement projects utilizing the Iowa Model for Evidence Based Practice©
   - Create improved efficiency
   - Allow better stakeholder engagement and better project outcomes
   - All projects will be done in a way that allows for projects to be used a Magnet© story

Standardization

- Benefits
  - Improved efficiency, eliminate siloed work, and increased transparency
  - Better engagement from stakeholders
  - Ability to set appropriate goals and deliverables
  - Proper participants
  - Better ability to achieve project goals
  - Better patient outcomes

Process Overview

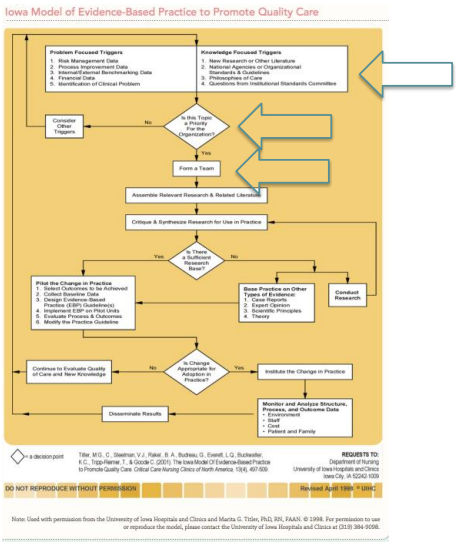
1. Project leader completes standardized form adapted from the Iowa Model of Evidence Based Practice©
2. Submit completed form to Nurse Executive Council (NEC) and the Management Communication Meeting via e-mail
3. Leaders will review the proposed project and contact the project leader if they believe their department is a stakeholder in the project
4. Team leader will then proceed with the usual project planning, making sure to involve the identified stakeholders

Process Overview

1. Project leader completes standardized form adapted from the Iowa Model of Evidence Based Practice©
2. Submit completed form to Nurse Executive Council (NEC) and the Management Communication Meeting via e-mail
3. Leaders will review the proposed project and contact the project leader if they believe their department is a stakeholder in the project
4. Team leader will then proceed with the usual project planning, making sure to involve the identified stakeholders

Page 5
John Muir Health – proprietary and confidential

Ç



Description of problem:

Trigger:

___Risk Management
___ Process Improvement
___Internal/External Benchmarking Data
___ Identification of Clinical Problem
___New Research/literature
___National Agencies/Organizational Standards & Guidelines
___Philosophies of Care
___ Questions from Institutional Standards Committee

Is this an organization priority?

Contact:

Magnetizing

- Projects must have 4 data points
  - 1 pre- implementation (that shows need for project)
  - 3 post- implementation (to show sustainability)

  - Make sure to connect with Program Director, Professional Practice and Magnet© for guidance with projects

Conclusion

A standardized process will allow:

- Active stakeholder engagement
- Organizational transparency
- Achievement of project goals
- Allow Magnet© standards to be maintained at all time