Tool #3: Unit-Level Problem Identification and Prioritization Exercise

Overview: The goal of this tool is to provide bedside nurses with an opportunity to apply systems thinking to daily unit practice. The tool provides participants with a framework and structured activities for elevating problem recognition skills from an individual patient to the unit’s broader patient population.

Type of exercise: Investigative activity

Staff resources required: None

Time required: Approximately five hours across one week for problem surfacing; 30 minutes for concluding discussion

Targeted skill: Systems thinking, problem recognition, and problem prioritization

Tool contents and intended audience:
- Tool Implementation Guide Manager/Educator
- Staff Exercise Frontline Nurse
- Evaluation Guide Manager/Educator
- Discussion Guide Manager/Educator

Tool Implementation Guide

I: Select frontline staff members to complete this exercise. This tool is most applicable for high-performing staff members who have the capacity to perform observation and analysis in the course of their daily practice.

II: Share this exercise with participating staff members and agree upon a deadline. The Center recommends setting a deadline of one to two weeks after sharing the exercise with participants. Establish regular check-ins across the exercise period to answer staff questions.

III: Assess the exercise using the Evaluation Guide on page 17. Use the Discussion Guide to initiate a conversation about participants’ experiences completing the exercise and their surfaced problems.
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Step One: Spend one week closely observing your practice and the practice of others on your unit. Your goal is to identify potentially inefficient processes, near-misses, and circumstances in which you or your peers struggle to deliver safe care.

Step Two: Answer the questions below based on your observations. Be as specific as possible.

1. Were there incidents of patient harm or near misses? If so, record them below.
   Sample: Elderly patient fell after receiving Klonopin
   a. ___________________________ e. ___________________________
   b. ___________________________ f. ___________________________
   c. ___________________________ g. ___________________________
   d. ___________________________ h. ___________________________

2. Based on your observations, can you predict how the next incidents of patient harm (or near misses) will occur?
   Sample: Pressure ulcer in peds patient with spine injury
   a. ___________________________
   b. ___________________________
   c. ___________________________

3. What care processes take longer than they should?
   Sample: Locating supplies for IV insertion
   a. ___________________________
   b. ___________________________
   c. ___________________________

4. Do any potential emergency situations lack defined protocols? Which ones?
   Sample: Emergency CT scan
   a. ___________________________
   b. ___________________________
   c. ___________________________

5. For which policies or protocols do staff struggle to reach 100 percent compliance?
   Sample: Hand washing prior to entering patient rooms
   a. ___________________________
   b. ___________________________
   c. ___________________________

6. What generates the greatest number of complaints from patients, physicians, or staff members about your unit?
   Sample: Patients dissatisfied with discharge education according to Press Ganey surveys
   a. ___________________________
   b. ___________________________
   c. ___________________________
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Step Three: Review your answers to the previous six questions. Use the prompts below to identify the problems that have the greatest impact on care quality and write the three biggest problems on the blank lines below.

Which of the problems address:
- needs of a high-risk patient population?
- the greatest unit quality concerns?
- persistent staff cultural concerns?
- care processes that are more dangerous than others?
- institutional strategic goals that the unit is falling short on?
- care process that you are passionate about improving?

Sample: Documentation of Joint Commission Core Measures in the EMR

a. 

b. 

c. 

Step Four: Write the problems you identified in Step Three in the table below.

Step Five: For each problem, use the scale in the table to rate its likelihood of occurring, its severity, and its likelihood of detection.

Step Six: Multiply the three scores to get a single Risk Priority Score for each problem.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Likelihood of occurrence (1=rare, 10=frequent)</th>
<th>Severity of consequence (1=minor, 10=catastrophic)</th>
<th>Likelihood of detection (1=extremely likely, 10=extremely unlikely)</th>
<th>Risk Priority Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample: Physician fails to use full drape during central line insertion</td>
<td>8</td>
<td>x</td>
<td>7</td>
<td>x</td>
</tr>
</tbody>
</table>

Step Seven: Use the Risk Priority Score to identify the highest-scoring problem. Verify that the problem can be inflected by a change in practice. If the problem is not actionable, move to the next-highest-scoring problem until you find one that is actionable. List that problem below.

Key Problem: