

Quality and Safety Series

Process Observation

OBJECTIVES

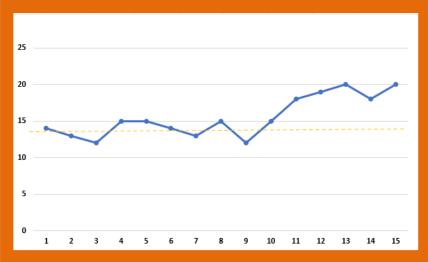
Discuss the performance pitfall related to non-compliance.

- Define process observation.
- Explore process observation tools.
- Discuss how to action results of process observations.



Performance Pitfall





You've completed a successful quality improvement project.
You've sustained the gains for 9 months. However, the last 6 data points have shown "drift."

- What do we do?
- How do we find the problem?
- What has changed?



Frontline Compliance

State of the Union



What Should Happen

- Processes
- Process maps
- Policies
- Procedures
- Created in the conference room

Frontline Actions



What Actually Happens

- Workarounds
- Shortcuts
- Deviations
- Knowledge deficits



Compliance



"What gets measured gets managed."

—P. Drucker

One of the biggest barriers to sustainability is lack of compliance monitoring.

Process observation is key!



Go to the Gemba!

"Go to the Gemba" is a Japanese term used by Six Sigma that means to go to the actual place or where the work is happening.





Get out of the office or conference room.

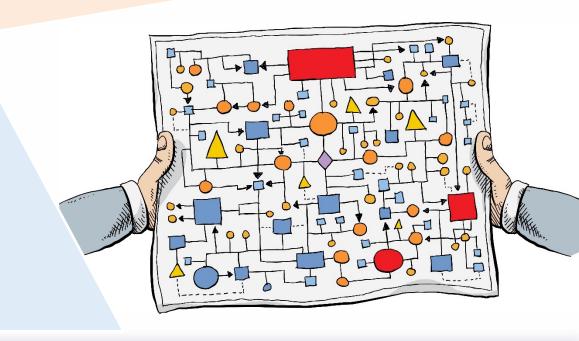
Observe the process and talk to the frontline staff.



What Is Process Observation?

Process Observation—uses a standardized tool that allows the observer to collect important information about a process and/or identify deviations.

- It is a direct
 observation of
 the frontline staff
 performing a specific
 process.
- Use your process map as a foundation.
- For complex processes, focus on a department or break the process into components.





Keys to Performing Process Observation



- Clarify the purpose of the observation with the team.
- Create a standardized data collection tool based on key steps for your current process.
 - List steps in order.
 - Add additional indicators, such as time to perform step(s), wait times, etc.
- Train all observers to use the tool in the same way.
- Perform multiple observations.
 - Can be a sample if dealing with a large volume.
 - Include all shifts.
 - Observe on various days of the week.
 Don't forget weekends!
 - Look for interrater reliability.



Example of a Process Observation Tool

lealthcare		ted Infection (HAI) Pr	ogram Adh	nerence Monito	oring	Assessment Dat Completed by: Unit:	e:
	_	edback of results to staff can in may be performed in any type	•		e. Use this tool to	identify gaps an	d opportunities for
		t 10 HH opportunities per unit. was performed. Record the to					hand hygiene opportunity yo
HH Opportunity	Discipline			ity was observed? (selec			Was HH performed for opportunity observed? ✓ or Ø
Example	N	☐ before care/entering room* *Remembe	□ before task r: Hand hygiene sho	after body fluids Dould be performed before a		on leaving room	•
HH1.		☐ before care/entering room	☐ before task	☐ after body fluids ☐	after care up	on leaving room	
HH2.		☐ before care/entering room	□ before task	☐ after body fluids ☐	after care up	on leaving room	
ннз.		☐ before care/entering room	☐ before task	☐ after body fluids ☐	after care up	on leaving room	
HH4.		☐ before care/entering room	☐ before task	☐ after body fluids ☐	after care up	on leaving room	
HH5.		☐ before care/entering room	☐ before task	☐ after body fluids ☐	after care up	on leaving room	
нн6.		☐ before care/entering room	☐ before task	☐ after body fluids ☐	after care up	on leaving room	
НН7.		☐ before care/entering room	□ before task	☐ after body fluids ☐	after care up	on leaving room	
нн8.		☐ before care/entering room	□ before task	☐ after body fluids ☐	after care up	on leaving room	
ннэ.		☐ before care/entering room	☐ before task	☐ after body fluids ☐	after care up	on leaving room	
нн10.		☐ before care/entering room	☐ before task	☐ after body fluids ☐	after care up	on leaving room	
Disciplines: CNA = Nurse A D = Dietary	ssistant	N =Nurse P = Physician RT = Respiratory Therapist		S = Student VIS = Visitor VOL = Volunteer		cial Worker Other, Specify Known	Opportunities: ✓ = Opportunity Successful Ø = Opportunity Missed



Example of a Process Observation Tool (cont.)

Hand Hygiene/Personal Protective Equipment (PPE) Monitoring Tool for Nursing Homes																										
Resident Care Unit/Dept.:										Month/Year:											Monitor's Initials:					
Hea 1 = P	Alcohol I Ithcare \ hysician/Pr espiratory	Worker T	3 =	Phy:	sical/	Occup	n patior rse (R	nal/S						cense	ed Vo	catio	nal N									es observed or NA, leave blank.)
# Observations	Date	Time	Health- care Worker Type	Hand Hygiene	BEFORE Room Entry			Transmission-based	Precautions		COVID-Specific PPE	(face mask/respirator/	face shield/goggles/etc.)	Gloves Worn		Hand Hygiene Before	Donning Gloves	Gown Worn		Gloves and Gown	Removed Upon	Room Exit	Hand Hygiene Upon	Room Exit		Comments
	Month, Day, Year	Day, Evening, Night	See Key	Yes HR	Yes HW	No	Y = Contact	Y = Droplet	Y = Enteric	z	Υ	N	NA	Y	N	Y	N	Y	N	Y	N	NA.	H S	Yes HW	No	
1																										
2																										
3				L							L			L		L		L		L			L			
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10																										
	Totals										Г															

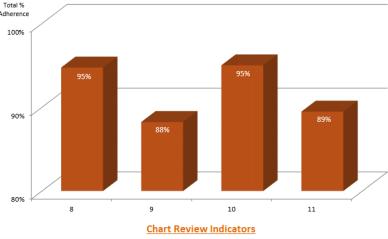
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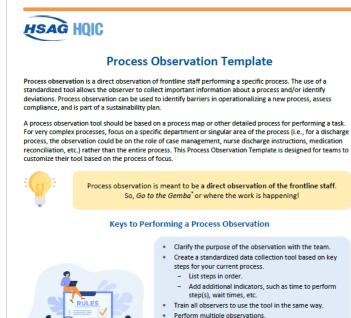
More Advanced Example

		Foley Cathete	er Observation and Qualit	ty Tool
Date: Number of I	Patient Census: Patients with Devices:		NPC= Not placed correctly	
Complete for each Indwelling Catheter Fo	ley in use: COMMENTS	Foley 1	Foley 2	Foley 3
Direct observation	ROOM #			
Is a closed system being maintain Is the Foley secured to the patien urethral tension?				
3. Is the bag below the level of the 4. Is the tubing from the catheter to dependent loops? 5. Is the tubing secured to the bed opulling on the entire system?	the bag free of			
 Is the bag hanging free without to Does the patient have an individe marked with his/her name and re 	ual measuring device			
Total Positive Per Patient		0	0	0
Total % Adherence Per Patient Chart Review 8. Is there documentation indicating inserted the Foley and is perineal of 8a. Note the department/unit where inserted and when perineal care v. 9. Is there documentation available necessity? 10. Is there documentation available the insertion bundle? 11. Has there been a check for Foley today?	are being performed the Foley was vas last performed indicating Foley e for completion of	0.0%	0.0%	0.0%
12. What criterion is noted?	_			
13. Comments	_			
Total Positive Per Patient		0	0	0
Total % Adherence Per Patient		0.0%	0.0%	0.0%

Chart Review--Foley Catheter



HSAG HQIC Process Observation Template



HSAG HQIC

Process Observation Template

Step	Description	Staff Member	Compliance	Reason for Non-Compliance	Observations

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Page 12

*"Go to the Gemba" is a Japanese term used by Six Sigma that means to go to the actual place or where the work is happening.

Include all shifts

- Can be a sample, if you are dealing with a large

 Look for interrater reliability (the percentage of agreement among independent observers).

Observe on various days of the week.
 Don't forget weekends!

Page | 1



Now What?



- Analyze the results.
 - Adapt the HSAG HQIC Process
 Observation Tool to an Excel document.
 - A drop-down for "Reasons for Non-Compliance" might need a baseline first.
- Focus on the areas of non-compliance.

- Convene the team to discuss barriers and solutions.
 - Don't forget frontline staff!
- Use PDSA* for a quick test of change to adapt your process to overcome barriers.
- Remember, education related to knowledge deficit can be a barrier.
 - Education is a Level III, weaker action in the action hierarchy.



Key Take-Aways

- A frequent performance pitfall can be lack of process compliance with frontline staff.
- "State of the Union" refers to how things should be done.
- Process observation reveals what is actually being done.
- Process observation is a direct observation of the frontline staff performing a specific process.
- Use a standardized tool to collect important information about a process and/or identify deviations.
 - Workarounds, shortcuts, deviations, knowledge deficits

- Go to the Gemba!
- Perform routine audits, including various shifts, units, and days of the week (including weekends).
- Check interrater reliability among observers—strive for 95%.

Analyze observation data for trends.

 Use PDSA to adapt processes to overcome identified barriers.







Thank you!

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