

# SPARK



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Milwaukee, WI

# Systems Thinking With Reggie Raye, RN

*Liz Jensen*



# Nurse Led Learning



- Meet Reggie Raye, RN and what she is interested in doing
- Use system thinking approach to tether to reality
- Explore an example – Increasing frequency of med errors
- Work through a problem – Inconsistent completion of ADLs & Timely notification to Nurse



**Reggie Raye, RN**

*QAPI Expert*



**SPARK**



# Meet Reggie Raye, RN, QAPI Expert



## Experience:

- 24 years' experience as a nurse
- 20 years' experience in both SNF and AL
- Experienced with technology for connected vitals, fall prevention, and resident engagement

## Roles held:

MDS Nurse, Charge Nurse, DON,  
Director of  
Health & Wellness

## Other:

- A passion for Quality Assurance/Performance Improvement (QAPI)
- Serves as a leader on her organization's technology committee
- Enthusiastic about EHR systems for their data and reporting capabilities

# Reggie's Concerns & Plan



## Lack of resiliency in clinical and care processes

- Inconsistent staffing
- Leadership turnover
- "starting over" mindset

## Open to Tech-Enabled Solutions, but concerned

- Burden – does it add more?
- Risk - if unable to adapt to reality
- Cost – initial and ongoing?

## Plan

- Deep dive into systems with persistent problems
- People/Process/Product/Tech/Data
- Pain points/problems/barriers
- Finding opportunities to strengthen
- First up, Med Pass

### EXAMPLE: Systems Thinking – Increasingly Frequent Medication Errors

Readying and completing med-pass is complicated and time-consuming. Below is an example of the key people, processes, products, technology, and data/information flows involved. Arrows show connections and dependencies. Pain points/problems/barriers (in red) are noted.



People Who are the key people to consider?	Process What are the expected steps and processes involved?	Products What are typical products you might find in use? Where are they found or kept?	Technology What type & where might technology be used? What is needed for tech to be useful?	Data / Information Flow What information is generated? Where does it need to go? Who needs it & when?
Nurse  Staff nurse or agency nurse?	Review MAR, <u>check for changes</u> ; retrieve medications, VS & blood glucose done "Rights"-med, dose, route, reason, time, person	Meds – oral, liquid, injectable, creams  Med cart, med cups, water; syringes, alcohol wipes, hand sanitizer	eMAR software, bedside scanner Kiosk/C.O.W.	Medication orders flow from prescriber → pharmacy → eMAR → nurse  Labs VS, Glucose
Resident	Receive and take medications (or refuse)	Assistive devices, cup of water	Call light system	Documentation of administration/refusal recorded in EHR
Pharmacy staff	Receive order changes Dispense and deliver medications	Blister packs, delivery totes "Emergency dose"	Pharmacy dispensing system	Fill/delivery data feeds into eMAR and inventory system
Supervisor/Nurse Leader	Monitor timeliness, resolve issues, support staff	Audit logs, exception reports	Dashboards, alert system	Exceptions/incident reports flow up for oversight
Surveyors/QA staff	Observe compliance with protocols	Survey checklists	Compliance reporting dashboards	Reports compiled into QAPI/QA systems
CNA	VS done + documented	VS equipment	DS Smart Kiosk?	VS → EHR

#### Reflection:

- Where do you see the most fragile points in the workflow?  
Delivery delays, nurse interruptions, data not updated promptly so leaders miss issues.
- Where could technology or improved data flow help improve resilience, efficiency, or communication without adding burden? Real-time delivery tracking, automated alerts for delays, dashboards showing pass status across the shift. Appropriate, resident specific de-prescribing initiatives reduces overall number of meds to pass.



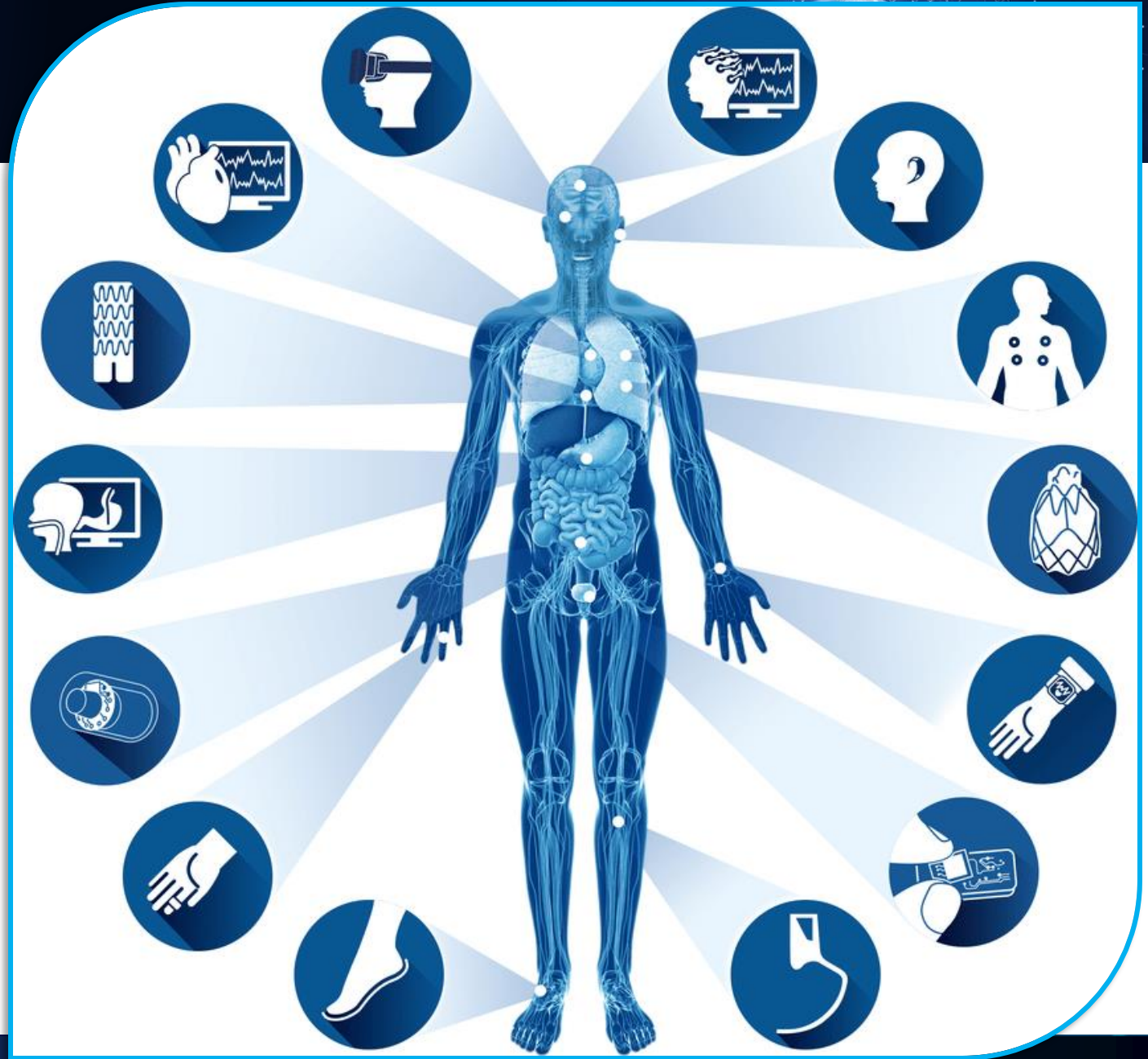
# Modify Systems Thinking

- People
- Processes
- Products
- Technology
- Dataflow





# Ambient Technology



# Robotics in Healthcare

