Impact of an Annual Retreat on Process Improvement in a Respiratory Therapy Section

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BACKGROUND: In order to fulfill the mission of providing superb respiratory care, managing respiratory care services requires communication and collaboration. To enhance communication and collaboration in our Section of Respiratory Therapy at the Cleveland Clinic Foundation, and to generate ideas for improvement, since 1996 we have conducted annual retreats for the Section, during which important challenges and opportunities are discussed in a large-group forum. The current report describes the retreat process and outcomes, namely the ideas generated during these retreats and the frequency with which ideas were implemented successfully. METHODS: The annual retreat brings together all clinical specialists, supervisors, and managers in the Section of Respiratory Therapy, along with the medical director of Respiratory Therapy and representatives of the staff from each shift. In advance of the annual half-day retreat, supervisors and clinical specialists are asked to write a brief description of things that need improvement and actionable proposed solutions to these challenges. These documents are reviewed by the supervisors, managers, education coordinator, and medical director, and a list of discussion topics for the retreat is formulated. The retreat day begins with a brief introduction and summary of the year's activities and then encourages open-ended discussions regarding the various topics, with the explicit, repeated goal of generating solutions. Minutes are kept to identify specific action items, a list of which is visited repeatedly throughout the year, to assess progress toward successful completion of each action item. In the current analysis, the primary outcome measures are the number of ideas generated as action items during the retreats and the frequency with which these ideas have been implemented. RESULTS: Over the 8 years of annual retreats, 103 action items have been generated, of which 84% (n = 87) have been successfully implemented or completed. As evidence of the importance of this group-based activity, we cite several examples of suggestions and action items that were felt to uniquely represent group process and wisdom and which were not proposed beforehand by individuals. CONCLUSIONS: On the basis of this experience, we recommend conducting annual respiratory therapy department retreats. We believe the benefits include collective problem-solving in a public forum to identify solutions not advanced by individuals. Also, we believe that the direct communication in such retreats contributes to enhanced morale, further evidence of which is the very low turnover rate among our respiratory therapists during the 8 years in which we have conducted annual retreats. *Key words: respiratory care, medical staff, group processes, program evaluation.* [Respir Care 2005;50(12):1654–1658. © 2005 Daedalus Enterprises]

Introduction

Principles of organizational development hold that organizations perform best when individuals are empowered, when teamwork is practiced, and when communication is open and effective.[1,2] The Section of Respiratory Therapy at the Cleveland Clinic Foundation is large (ie, with approximately 100 full-time equivalents) and, like many such sections, is faced with the challenges of caring for a growing number of increasingly sick patients in a

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Table 1. Schedule for the Respiratory Therapy Retreat, February 25, 2004

7:45–8:00 AM	Breakfast
8:00–8:20 AM	Welcome/opening remarks: Medical Director
8:20–8:35 AM	Review of Respiratory Therapy Section work volumes: Manager
8:35–10:15 AM	Discussion: issues and challenges
10:15–10:30 AM	Break
10:30 AM–12:15 PM	Discussion continues
12:15 PM	Lunch

cost-attentive climate. In our attempt to optimize the clinical performance of our large team, we have invoked these organizational development principles in conducting the activities of the section. Specific strategies to enhance communication have included quarterly shift meetings among staff therapists, the medical director, and supervisors; weekly meetings between all supervisors, the education coordinator, and the medical director; and use of e-mail to disseminate information to all therapists. An additional strategy to enhance creativity, participation, and communication is an annual section retreat, first implemented in 1996, at which all supervisors, clinical specialists, the education coordinator, and selected staff therapists from all shifts convene to consider common challenges and to problem-solve as a group. To offer suggestions and insight to other respiratory therapy departments that are considering strategies to enhance departmental communication and function, the current report describes the structure of these annual retreats and summarizes their impact over our 8-year experience. Specifically, as primary outcome measures of this study we assessed the number of ideas generated during these retreats and the frequency with which these ideas have been implemented in our section.

Methods

The purpose of the retreat is to convene a large group of therapists and to harvest their experience for understanding current challenges and developing actionable solutions (ie, ideas for solutions that can be implemented) to improve respiratory therapy services at the Cleveland Clinic Foundation. In the context that the mission of the department is to provide superb care, to advance the field of respiratory care, and to promote educational advancement, proposed topics may involve any of these aspects.

In order to permit full planning, the date of the annual half-day retreat is determined several months in advance. Then, one month before the retreat, all therapists with supervisory responsibility are asked to submit a form in which they list opportunities for improvement in their areas and proposed solutions that can be implemented. Proposals are collected and reviewed by a team of supervisors, the manager, education coordinator, and the medical director of respiratory care. On this basis, a list of discussion topics is assembled for the retreat.

Table 1 presents a characteristic schedule for the retreat day. The day begins with a brief presentation by the medical director that provides an overview of the clinical, educational, and scholarly activities of the Section, followed by a presentation by the manager, summarizing the volume and types of services provided over the past year. By design, most of the day is allocated to discussing the agenda items assembled in advance, with ample time allocated for open discussion and for new topics suggested by any of the attendees. Each retreat has been facilitated by the medical director (JKS), who has graduate training and experience in organizational development. During the retreat, minutes are recorded and reviewed to identify specific action items or ideas that are considered to have merit and that can be implemented. The list of action items is then circulated to all attendees and to all members of the Section of Respiratory Therapy within several days after the retreat. The list of action items becomes a manifesto for change, in that the list is revisited repeatedly after the retreat to assess progress toward successful implementation or resolution of each item.

In the current analysis of the impact of the retreats, the primary outcome measures are the number of action items generated in the retreats and the frequency with which the ideas are implemented successfully. Ideas were deemed implemented if the action item was carried out at any time following the retreat in which it was generated. Because the list of action items is reviewed periodically after each retreat, the time to implement after the retreat is usually very brief (ie, days to several months).

Action items were categorized by one of the study authors (JKS); agreement on the classification was achieved in a discussion among the medical director, manager, education coordinator, and all supervisors in the section.

Results

First organized in 1996, 8 retreats have been conducted to date. Review of the agendas for these 8 retreats shows the discussion topics commonly fall within several broad categories: communication, staffing, clinical operations, general operations, research/scholarship, and miscellaneous (eg, possible use of uniforms, and whether to use rolling stands or to carry laptops used for the information management system).

Overall, review of all the action item lists from the 8 retreats indicates a total of 103 items generated, of which 87 (84%) have been implemented as of June 2004. Figure 1 presents the number of action items generated with each

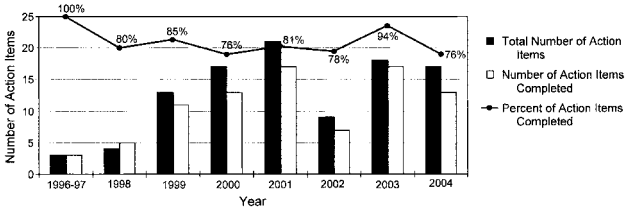

Fig. 1. Number and percent of action items proposed (black bars) and implemented (white bars) from the retreats of the Cleveland Clinic Foundation's Section of Respiratory Therapy.

retreat and the percent of such action items for which interventions were successfully implemented (mean 84%, range 76–100%). As shown, a trend toward an increasing number of action items with more recent retreats is evident. As examples, Table 2 presents action items from the 2004 retreat, of which 88% were successfully implemented within 5 months of the retreat.

Review of the minutes of all the retreats and of the resultant action items shows many items that had great merit by virtue of improving the function of the section but that were not considered before the retreat; in other words, ideas and suggestions were generated during the retreat session that had not been formulated beforehand by any one of the individuals participating but that represented the success of the group process during the retreat. Two examples are cited to demonstrate ways in which ideas were uniquely developed by the group. First, at the 2000 retreat, the topic of how therapists were evaluated was introduced by one of the attendees. Though no specific proposal had been made before the retreat, discussion of the topic during the retreat generated a spirited and broad-reaching discussion in which the importance of incorporating a 360-degree peer review was emphasized. An action item from the retreat was to develop a committee of therapists to further explore the proposal to incorporate peer review into therapists' evaluation. Such a committee was formed soon after the retreat and a proposal was developed for amending the therapist evaluation process to include evaluations by peers, direct reports, and supervisors. The proposal was implemented soon thereafter and remains the method by which therapists are evaluated in our section today.

As a second example, the 2004 retreat generated a strategy for documenting therapists' completion of required skills checks that had not been imagined before the retreat. Specifically, group discussion during the retreat fostered the idea that therapists should submit a form completed by the individual who oversaw the skill demonstration, thus confirming completion of the skill check. It was decided that the certifier could be a supervisor or a peer who had already completed the skills check her/himself for the current year. Another idea was to collect the forms in a box placed in a prominent place within the section and to have supervisors collect these forms once weekly in order to maintain a current roster of those who have completed their skills checks. In this way, therapists whose forms were completed by a certifier could deposit the forms quickly after completion and be credited for having completed the skills check in a timely way. This system for obtaining skills check certification and for submitting forms was implemented within a week after the 2004 retreat and remains in use currently.

As part of this analysis of the retreats, we also reviewed all items that were not implemented regarding reasons for not implementing. Of the 18 action items (17%) not implemented, 4 reasons accounted for failure to implement. These included: (a) the idea was deemed undesirable on further reflection following the retreat (12 items [67%]), (b) time or resource limitations precluded implementation (2 items [11%]), (c) the idea was deemed inadvisable after an initial trial (3 items [17%]), or (d) implementation was deferred pending the availability of needed technology resources (1 item [5%]).

Discussion

In this summary of our experience with annual retreats of therapists in the Cleveland Clinic Foundation's Section of Respiratory Therapy, several conclusions are offered:

1. The main benefit of the retreats has been their providing a forum for collective problem-solving and identifying solutions to common challenges, which would not have been possible outside of a group activity.
2. Other benefits of the retreat include enhanced, direct communication among all the therapists in the section and, we believe, enhanced morale. In support of the enhanced morale that we ascribe to the participatory environment in our section (of which the retreats are another manifestation), the annual turnover rate among therapists in our section[3] has been very low during the 8 years in which we have held retreats: 10% in 1996 to 7% in 2003 (mean 7.3%). Such a participatory environment is affirmed by conducting the retreat and by giving weight to its importance as a forum for collective problem-solving.
3. To the extent that enhancing communication, participation, and problem-solving to optimize the function of the section represents important organizational development interventions, we recommend retreats to others who are also addressing issues regarding clinical operations, staffing, and research/scholarship.

Our experience affirms prior experience that retreats among teams can be effective forums for collective problem-solving and enhancing communication, as well as for team-building.[4,5] Still, in the specific context of health

Table 2. Action Items Generated in the 2004 Retreat

Action Item	Category	Outcomes
1. Revise skills check process to increase compliance and timeliness.	Operations	Implemented new way of collecting skill-check forms and deadlines, in which they are handed in.
2. Revise the ICU and new employee orientations.	Operations	The orientation process was revised to better prepare new employees, and the ICU orientation was adjusted to provide the therapist with an all-encompassing training schedule and to better accommodate our staffing needs.
3. Implement a second round of management information system training.	Operations	Pending
4. Identify and evaluate management information system "sync" locations.	Operations	Ports were identified and evaluated, but, because of unsatisfactory "synching" times, laptops will not be used for charting on regular nursing floors.
5. Use management information system e-mail to communicate to the staff.	Communication	All therapists must check their e-mail on a regular basis to be notified of new patient orders, departmental news, meeting minutes, and miscellaneous information.
6. Hard-wire a management information system laptop in each ICU.	Operations	Laptops were hard-wired to our information management system in each ICU.
7. Work with information technology and management information system to improve laptop speed.	Operations	Pending
8. Schedule frequent ICU clinical specialist meetings.	Operations	Two meetings have taken place in the 3 months since the retreat, to discuss pressing issues.
9. Attach a folder with flow sheets to each BiPAP machine.	Operations	All hospital-floor BiPAP machines now have an attached folder that contains several of our flow sheets.
10. Collect flow sheets from different hospitals to get ideas for revising ours.	Operations	Flow sheets from several hospitals inside and outside of the Cleveland area were reviewed.
11. Communicate using message boards in the ICUs.	Communication	Message boards are in place and used frequently.
12. Analyze UPTO occurrences on weekdays versus weekends.	Staffing	UPTO hours were analyzed; it was determined that a greater percentage occurred during the week.
13. Revamp our UPTO system.	Staffing	Rewards system put into place for therapists who meet the established attendance requirements, in hope of curbing unwarranted call-offs.
14. Vote on uniform issue.	Miscellaneous	Staff was polled twice and results were inconclusive, so it was decided not to purchase matching uniforms for the staff at this time.
15. Look into providing a full-time employee for the subacute care facility.	Staffing	It was determined, after reviewing the work volume in the subacute care facility, that a dedicated FTE is not warranted.
16. Improve equipment stocking.	Operations	Equipment technician now works on days when supplies have been historically low, and students working as equipment technicians are being better utilized.
17. Purchase bedside spirometer with capital expenditure.	Operations	In process

ICU = intensive care unit
BiPAP = bilevel positive airway pressure
UPTO = unscheduled paid time off
FTE = full-time equivalent

care, the issues of team-building, group process, and enhancing communication in health care have received relatively little attention,[6,7] with even less attention given to these issues in respiratory care. We are aware of several reports, including one from our institution,[7] that have examined the value of organized retreats for medical house officers. For example, our experience with a house-staff retreat of Cleveland Clinic internal medicine trainees showed that the retreat was well received and deemed helpful by attendees, to enhance their appreciation of the value of teamwork.[7]

In an earlier report regarding house-staff group activities, Wipf et al[8] observed that an annual intern training course was associated with improved teaching scores, as measured by a standardized clinical teaching assessment form. In another study, Kasuya and Nip[9] reported an intern retreat that emphasized team management and other leadership skills. Self-assessment survey results indicated that participants became more confident in their ability to lead a ward team and also gained better appreciation for their roles as team leaders and managers. Also, McNair et al[5] described a 3-year program regarding primary-care resi-

dent teamwork. Finally, the business journal *Fast Company* reported on the benefits of teamwork in the obstetrics service at Parkland Memorial Hospital.[10] That report cited the importance of modeling participative, nonhierarchical behavior, especially in the context of a highly structured team, and provided a quote from an incoming fourth-year resident who, while mopping the floor, stated, "I'm not too good to clean rooms, to mop floors, to take vital signs. And when a new intern watches me clean rooms, she'll say: 'If a fourth-year doc can do it, I can do it'."[10]

Several limitations of this study warrant consideration. First, although we have discussed enhanced morale and lower rates of respiratory therapist turnover in the context of the retreats, whether these benefits can be attributed to the retreats themselves is uncertain. Indeed, it is possible that these benefits, which have been observed over the same interval in which retreats have been conducted, are a result of a climate of direct communication and professionalism in our section, of which the retreats are another manifestation.

A second limitation is that, in the context of this retrospective review of minutes and action items generated in each retreat, we did not record the precise interval between the retreat during which an idea was generated and the time of the idea's implementation. Nonetheless, our recall and current review of action items from the 2004 retreat indicates that this interval is generally short (ie, days to months).

Conclusions

In summary, this experience suggests that group retreats by a respiratory therapy section represent one strategy to harvest ideas and enhance organizational function. Other favorable trends that have developed over the 8-year span of the retreats (eg, enhanced morale and decreased turnover rate among respiratory therapists) cannot be confidently ascribed to the retreats, but may also be benefits of a climate of direct communication and professionalism also demonstrated by the retreats. On the basis of this overall favorable experience, we recommend this activity to others who are also striving to solve challenges in optimizing the delivery of respiratory care services.

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