# Stakeholders meetings

Team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month/year: \_\_\_\_ / \_\_\_

Names of stakeholders interviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suggestions:

1. Meet with stakeholders once, and then revise analysis based on additional conversations, phone calls, emails.
2. Start discussion by stating your proposed aim. Do you need to modify your aim?
3. Not every item below is relevant and so not every item needs discussion.

|  |  |
| --- | --- |
| **Patients** |  |
| Safety: |  |
| Service/satisfaction: |  |
| Other benefit/harm: |  |
| **Providers** |  |
| Make work smoother and easier: |  |
| Prevent malpractice: |  |
| Revenue loss/gain: |  |
| Other benefit/harm: |  |
| **Nurses** |  |
| Make work smoother and easier: |  |
| Prevent malpractice: |  |
| Other benefit/harm: |  |
| **Institution** |  |
| QI incentive payments from CMS/other: |  |
| Reputation: |  |
| Revenue loss/gain: |  |
| Prevent malpractice: |  |
| Other benefit/harm: |  |
| **Patrons – external:** |  |
| Fulfillment of mission: |  |
| Other benefit/harm: |  |
| **Other stakeholders** |  |
| Other benefit/harm: |  |

What do you r stakeholders think are the root causes (ask for feedback on your Ishikawa)?

How is process currently done (ask for high level feedback on your flow chart ***if*** you have started on)?

* How are clinical decision currently made? Is a specific published guideline followed?

What do you r stakeholders think are potential solutions?

Lastly, do your stakeholders know of a patient who ‘fell through the cracks” and exemplifies the need to improve this process?