From Noticing to Doing – Making all the Difference

Going the Magnificent Mile with the QSEN Competencies
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Teamwork and Noticing

https://www.bing.com/videos/search?q=take+the+bus&view=detail&mid=F0D4E22945C134804F93F0D4E22945C134804F93&FORM=VIRE

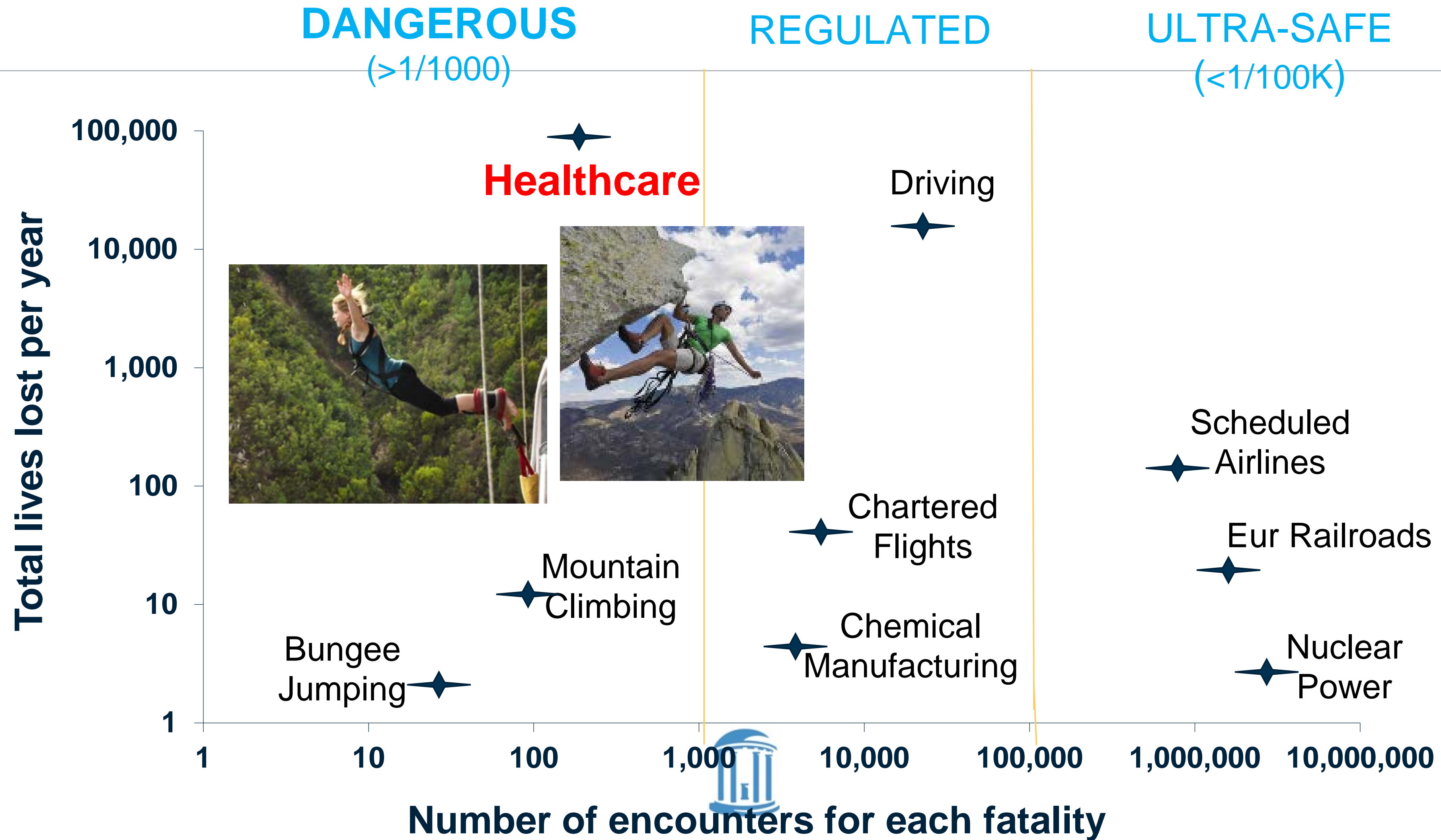
Reflecting on the beginning . . .

All health professionals should be educated to deliver *patient-centered care* as members of an *interdisciplinary team [interprofessional]*, emphasizing *evidence-based practice*, *quality improvement approaches*, and *informatics*.

Greiner, A. C. & Knebel, E. (Eds) Committee on the Health Professions Education Summit (2003). Health professions education: A bridge to quality. Washington, DC: National Academies Press.

Picture source - http://jinterprofessionalc.blogspot.ca/2012/01/changes-in-attitudes-toward.html

How Hazardous Is Health Care?



Lucian Leape, 2/2001

Arlington National Cemetery

400,000 preventable deaths per year James, JT, 2013

James, J. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety, 9*(3), 122-128.
http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx

http://www.fabcon-usa.com/wp-content/uploads/2013/11/2011-4-3-Pentagon-Arlington-TGR-118e.jpg

Noticing is integral to the everyday practice of nurses; it is the pre-cursor for clinical reasoning, informing judgement and the basis of care. By noticing the nurse can pre-empt possible risks or support subtle changes towards recovery.

WATSON, FIONA AND REBAIR, ANNESSA (2014) *THE ART OF NOTICING: ESSENTIAL TO NURSING PRACTICE*. BRITISH JOURNAL OF NURSING, 23 (10). PP. 514-517. ISSN 0966-0461

Tanner’s Clinical Judgment Model

Noticing

Interpreting

Responding

Context
Background
Relationship

Expectations

Initial Grasp

Reasoning Patterns
Analytic
Intuitive
Narrative

Action

Reflection-in-Action

Outcomes

Reflection-on-action and Clinical Learning

Reflecting

Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education*, 45(6) 204-211.

Noticing to Doing?

Training

- Patterns and meaning
- What is the worse it can be?
- Avoid anchoring, premature closure, confirmation bias

Fatigue

- 12 hour shifts

Voice

- Communication, Collaboration, Teamwork
- TeamSTEPPS two challenge rule
- TeamSTEPPs CUS Words

Is *Good* Enough?

99.9% would be considered outstanding for

Return on investment

Research questionnaire response rate

Where does healthcare fall regarding 99.9% as the standard of excellence?

Video - http://www.media-partners.com/meeting_opener_videos/is_good_enough.htm

Run Time 3:20 minutes

Changing our Perspectives

Video was about two different percentages

- 99.9%
- .1%

But really *not* about two different *percentages*

Not even about two different perspectives

Rather about *two different groups of people*

- People of the 99.9%
- People of the .1%

"is good enough?", 2008 Media Partners

Good Enough – is it??

Concept of "good enough" is at heart of all mediocrity

- Software programs – released known defects
- Food products – shipped acceptable amounts of foreign matter
- Toys –manufactured with eye on profit vs. safety

Are we settling for good enough in healthcare?

Are we using "we are human and mistakes happen" as a mantra to excuse the harm"?

0.1% insignificant ONLY to those unaffected by them

"is good enough?", 2008 Media Partners

Using Story to develop QSEN Competencies

Story . . .

Puts faces to healthcare error and can create a sense of urgency to change

Applies knowledge and experience to real life situations – situated cognition

Ties actions to outcomes

Is memorable

Sue Sheridan

Cal (1995) **& Patrick** (1999) **Sheridan**

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/videos/ts_Sue_Sheridan/Sue_Sheridan-400-300.html

QSEN Competencies – Patient-centered Care & Quality Improvement

Patient-Centered Care

Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.

Quality Improvement

Use data to monitor the outcomes of care processes and use improvement methods to design and test changers to continuously improve the quality and safety of health care systems.

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J. , Johnson, J., Mitchell, P. Taylor Sullivan, D. & Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook,* 55(3) 122-131.

Sorrel King

Josie King (2001)

JosieKing.org

QSEN Competencies – Safety & Informatics

Safety

Minimize risk of harm to patients and providers through both system effectiveness and individual performance.

Informatics

Use information and technology to communicate, manage knowledge, mitigate error, and support decision-making.

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J. , Johnson, J., Mitchell, P. Taylor Sullivan, D. & Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook,* 55(3) 122-131.

Helen Haskell

Lewis Blackman (2000)

Tears to Transparency Series:
"The Story of Lewis Blackman"

Case Study – Key events

Day 1

- Pectus Excavatum 15-year old (co-morbidity – asthma)
- Epidural analgesic Ketorolac (NSAID) for pain management
- Bed space admitted to pediatric oncology versus

Day 4

- 5/5 severe, sudden abdominal pain
- No water, no solid food, no ambulation
- 152/86 115 bpm pain due to “constipation/gas” – oxycodone added
- Black circles under eyes, diaphoretic, distended abdomen

Nurse seems alarmed and leaves the room. She returns later and reports that his pain is due to gas and constipation.

What do you imagine made her dismiss her intuition?

Why premature close on a diagnosis of gas and constipation?

Power Gradients

Who?

Have knowledge but not confidence in reporting what they know

Important to overcome hesitancy

Include all team members in

patient care discussion and decision making – including

patient and family

Key events *continued*

Day 5

- SpO2 85 applied O2, 137/85 HR 142
- 4 am Severe abdomen pain 140/100 HR 140, R 28, pale nausea/weak
- Few hours later pain suddenly gone away

- 8:30 am NO BP – for 2 hours searched for BP cuff that worked and tried 12 different times with 7 difference cuffs

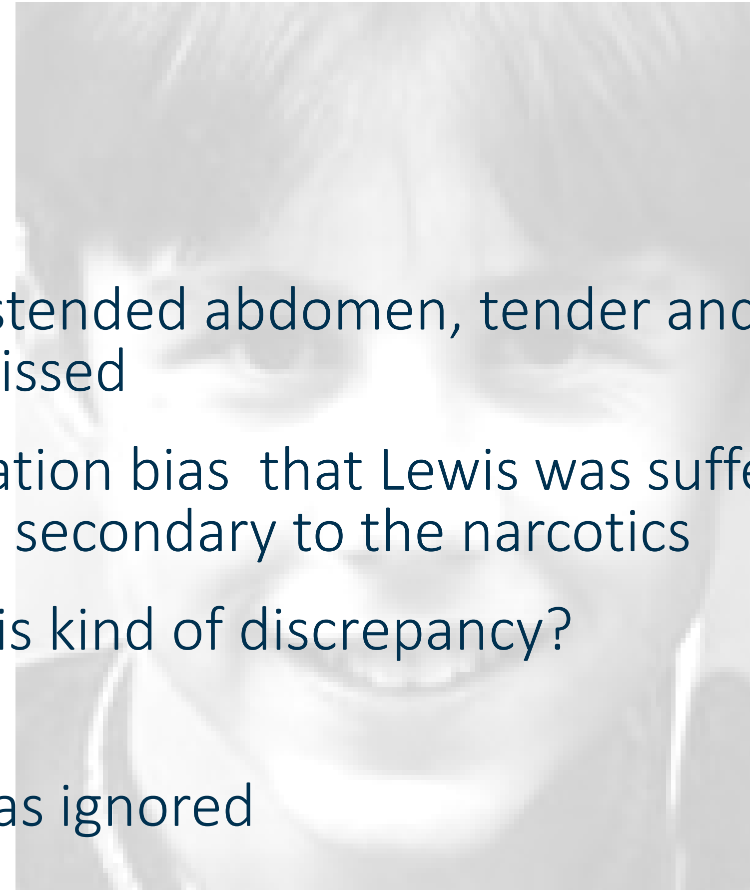
STOP and think – what is going on??

What are the signs and symptoms telling us.

Why go to equipment failure?

9:30 am Attending in surgery – receives message Lewis not doing well – incongruent with previous morning report that Lewis was doing well

Anatomy of Premature Closure



Lining up the Swiss Cheese holes . . .

- Admitted to oncology floor
- Low urinary output
- Night nurse concerned but concern about distended abdomen, tender and HARD, pale skin, diaphoretic – CONCERN dismissed
- Team had prematurely closed or had confirmation bias that Lewis was suffering from gas and constipation from probable ileus secondary to the narcotics

How should we equip our nurses to handle this kind of discrepancy?

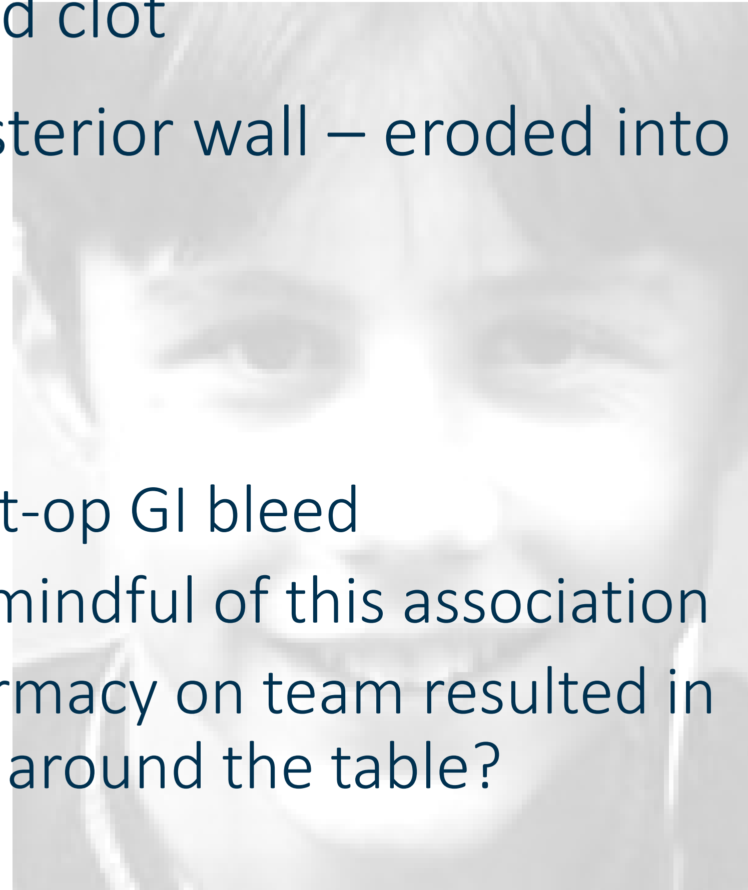
- CUS words/ Two Challenge Rule

- Impending SHOCK and circulatory collapse was ignored

Autopsy Report

2000cc blood in abdomen - 800 cc blood clot

Duodenum ulceration - perforation posterior wall – eroded into gastro duodenum artery



Notably

- 4 year before Ketorolac identified as post-op GI bleed
- Numerous Case report – caregivers not mindful of this association
- Black box warning – could including Pharmacy on team resulted in different outcome? Who else is needed around the table?

If Lewis had been ANYWHERE
but in a hospital he would be alive today
the hospital was the one place

we were not able to get him the medical attention he needed!

Interviews with Helen Haskell can be found at qsen.org

HELEN HASKELL

MOTHER

QSEN Competencies – Evidence-based Practice & Teamwork and Collaboration

Evidence-based Practice

Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Teamwork and Collaboration

Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J. , Johnson, J., Mitchell, P. Taylor Sullivan, D. & Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook,* 55(3) 122-131.

Effective Team Training in Action & . . .

AHRQ Mortality & Morbidity Cases

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

https://psnet.ahrq.gov/webmm

AHRQ.gov

PSNet
PATIENT SAFETY NETWORK

PSNet Search... Login

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1 - 20 of 378 results for

WebM&M Cases & Commentaries

WebM&M (Morbidity and Mortality Rounds on the Web) features expert analysis of medical errors reported anonymously by our readers and includes interactive learning modules on patient safety ("Spotlight Cases").

NARROW RESULTS Clear All

- Contains CME
- Spotlight Case

Approach to Improving Safety

- Communication Improvement 203
- Culture of Safety 25
- Education and Training 86
- Error Reporting and Analysis 48

Download Citations SHOW: 20 | 50 | 100 Basic | Expanded

CASES & COMMENTARIES

The Case of Mistaken Intubation

SPOTLIGHT CASE CME/CEU WebM&M

Maria J. Silveira, MD, MA, MPH; June 2016

An older man with multiple medical conditions was found hypoxic, hypotensive, and tachycardic. He was taken to the hospital. Providers there were unable to determine the patient's wishes for life-sustaining care, and, unaware that he had previously completed a DNR/DNI order, they placed him on a mechanical ventilator.

Discuss near misses
(why are they happening?)

Creating meaningful learning experiences

"What is essential for healthcare educators is helping students make the connections between acquiring and using knowledge. We call this ***teaching for a sense of salience."***

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating Nurses. A Call for Radical Transformation, p.94.* San Francisco: Josey-Bass.

Use Simulation to teach patient safety

Always have a target patient safety objective

Integrate QSEN/IPEC competencies

Use Standards of Best Practice Simulation

One more story . . . mine

PICC line and IV antibiotics to treat Infection

Line pulled the day before Thanksgiving

Returned to work on Monday after Thanksgiving 2010

In faculty meeting begin to have rigors, feeling really bad . . .

Sense of impending doom – wow - had read about that

Taken to ED around 6 pm – packed

Surviving Sepsis Campaign 2002

750,000 patients annually in US

30%-50% mortality

What are you most worried about?

Preparing safety workers

Often confidence valued over uncertainty

How do we help our learners express their uncertainty?

How do we create a culture in health care where “Calling for Help” is not seen as a sign of weakness but as a symbol of “Safety Excellence”?

The Faces of Medical Error…From Tears to Transparency The Story of Lewis Blackman Transparent Health®, 2009

Consider how you will help your healthcare practitioners *Stay CURIOUS*

What stands out?

What are you most concerned about for this patient (OUR patient)?

What else could it be?

What ACTION will you take? Why?

“Every system is perfectly designed to achieve the results it gets.”

Paul Batalden

Transforming Healthcare

There are some patients whom we cannot help.

There are none whom we cannot harm.

A. L. Bloomfield

Thank You!

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