The Future is Now: Designing Your Practice to Impact Patient Outcomes

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Self
Advocacy
Fundamentals
Evidence
Team
Yes I Will
Self
Number 1 Respected Profession

Nursing

Gallup Poll: 82% Honesty & Ethical Rating

So Why Don’t We Feel Respected?
Reclaiming Professional Respect

What Behaviors or Communications Make You Feel the Recipient of Respect?

Work Environment

Quality of Care You Provide to Patient & Families
Feeling of Respect or Not being Respected

- Respected
  - Feeling listened to
  - Feeling revered for their knowledge
  - Feeling trusted
  - Feel part of the group
  - Being acknowledged
  - Sense of belonging/contributing
  - Persons look out for each other and their support
  - Fairness
  - Free to speak
  - Opportunities to excel

- Not Being Respected
  - Disregarded
  - Not revered
  - Not trusted
  - Not supported
  - Not recognized
  - Closed conversation
  - Speaking in a tone that is demeaning
  - Ideas and opinions not considered a value priority
  - Unsafe, guarded, pressured, put down
The Nature and Causes of Disrespectful Behavior

- Barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect
  - Disruptive behavior
    - Inappropriate conduct, outburst, verbal threats, bullying
  - Humiliation, demeaning treatment
  - Passive aggressive behavior
    - Pattern of negativistic attitudes & passive resistance to adequate performance
  - Passive disrespect—suppressed anger
  - Dismissive treatment of patients
  - System disrespect
    - Patient waiting, hostile working conditions, fail to ensure the physical safety of staff.

Leape LL, et al. Academic Medicine, 2012;87(7):845-852
The Nature and Causes of Disrespectful Behavior

• Disrespect does the following;
  – Immediate aftermath; experience fear, anger, confusion, self-doubt, that can lead to error in decision-making
  – Long-term effects; Avoid the person inflicting hurtful behavior
  – Inhibits collegiality and cooperation key to teamwork
  – Cuts off communication
  – Undermines morale
  – Inhibits compliance and implementation of new practices
  – Diminishes joy and fulfillment in work and increases turnover

Leape LL, et al. Academic Medicine, 2012;87(7):845-852
Facts About Respect

• How we live our lives depends on whether we respect ourselves.
• The value of self-respect may be something we take for granted.
• We may discover how very important it is when our self-respect is threatened, or we lose it and have to work to regain it, or we have to struggle to develop or maintain it in a hostile environment.
• Respect is a foundational element of professionalism.
• It is part of everyday wisdom that respect and self-respect are deeply connected.

Leape LL, et al. Academic Medicine, 2012;87(7):845-852
Self Respect

Internal Dialogue

External Dialogue
Elevator Speech

• Florence Nightingale:
  – Role of the nurse is to put the patient in the best condition for nature to heal them

Mine:
  I help patients feel better and function better whether they have a disease or not
The Road to Respect

I spoke.
You listened.
I felt valued and honored.
You shared your opinion.
I trusted your wisdom.
The circle of respect was complete.
We saw in each other’s eyes are common humanity.
Now, moving to a zone of mutual affirmation, we felt safe to trust and learn and nurture in the give-and-take of life.

Yasmin Morais 2006
Advocacy
Advocacy can be seen as a deliberate process of speaking out on issues of concern in order to exert some influence on behalf of ideas or persons.

http://en.wikipedia.org/wiki/Advocacy accessed 03/05/2009
Broaden the Definition of Advocacy

“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.”

Florence Nightingale
Notes on Hospitals: 1859

Advocacy = Safety
Patient Advocacy/Safety Related to Clinical Practice

• Nurses knowledge of the Evidence based care
• Ability to deliver the care to the right patient at the right time, every time it is needed
• The ability to communicate patient concerns in a concise, data driven manner and take appropriate action
• Understanding that I am the voice of the patient
Why Effective Communication May Be Challenging for Nursing

- Self Respect
- Communication
- Advocacy
- Teamwork
- Safety Environment
The Silent Treatment: April 2011

- 85% of workers reported a safety tool warned them of a problem that may have been otherwise missed & could harm a patient.
- Safety tools include: handoff protocols, checklists, COPE, automated medication dispensing machines.
- 58% said they got the warning, but failed to effectively speak up & solve the problem.
- 3 “undiscussbale” issues: dangerous short cuts, incompetence & disrespect (4/5 nurses).
- 1/2 say shortcuts lead to near misses.
- 1/3 say incompetence leads to near misses.
- 1/2 say disrespect prevented them from getting others to listen or respect their opinion.
- Only 16% confronted the disrespectful behavior.

http://www.silenttreatmentstudy.com
“Our lives begin to end the day we become silent about things that matter”

Martin Luther King Jr.
Understanding Your Culture & Communication Strategies

How are you going to participate in fixing it?

Have you talked to......

If you Permit it you Promote it

Tweeners

Negatoids

Positrons
A good word is an easy obligation; but not to speak ill requires only our silence; which costs us nothing.

John Tillotson
Non-Verbal Communication
Speaking Up: Does a Plan Education Program Improve Advocacy

• Quasi-experimental design
• Intervention design to increase speaking up behaviors among nurses in situations were patient safety is in jeopardy
• 2 hospital, same health system
• 51 RN’s control group, 53 in intervention group
• Intervention; remove any sanctions, viewed video from CNO & CMO expressing commitment to back speaking up, discussion of organization obstacles, then individual obstacles, generate a personal action plan, planned peer support
• Results:
  – Significant increase in speaking up behaviors vs. control (p<.0001)

Courage

“Courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen”

Winston Churchill
What to Do Individually?

- Prevent from occurring through training on effective communication
- Deal in real time to prevent staff or patient harm
- Initiate post event reviews, action and follow-up
- Make it as transparent as possible
- Zero-tolerance policy and procedure
- Intervention strategy: code white
Communication Training
Communication Strategies

- Tools to help structure communication
  - SBAR for communication with Doctors: **Situation, Background, Assessment and Recommendation**
  - CUS Words: I am **Concerned**, I am **Uncomfortable**, This is not **Safe**

Use CUS words when assertion of your communication fails...things go wrong...concern expressed but mutual decision not reached or proposed action doesn’t happen in time frame agreed upon
What to Do Individually?

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Fundamentals
Missed Nursing Care

- Any aspect of required patient care that is omitted (either in part or whole) or significantly delayed.
- A predictor of patient outcomes
- Measures the process of nursing care

Figure 2. Elements of care most and least frequently missed. The solid bars represent the means across all 10 hospitals, and the range lines indicate the standard deviations.

## Patient Perceptions of Missed Nursing Care

### Table 2. Elements of Nursing Care by Ability of Patient to Report and Extent Missed*

<table>
<thead>
<tr>
<th></th>
<th>Fully Reportable</th>
<th>Partially Reportable</th>
<th>Not Reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently Missed</td>
<td>Mouth care</td>
<td>Ambulation</td>
<td>Patient assessment</td>
</tr>
<tr>
<td></td>
<td>Listening</td>
<td>Discharge planning</td>
<td>Surveillance</td>
</tr>
<tr>
<td></td>
<td>Being kept informed</td>
<td>Patient education</td>
<td>IV site care</td>
</tr>
<tr>
<td>Sometimes Missed</td>
<td>Response to call lights</td>
<td>Medication administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Response to alarms</td>
<td>Repositioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meal assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain medication and follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely Missed</td>
<td>Bathing</td>
<td>Vital signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hand washing</td>
<td></td>
</tr>
</tbody>
</table>

* IV, intravenous.

Kalisch, B et al. (2012). TJC Jour Qual Patient Safety, 38(4),
Missed Nursing Care*

- Impacted by poor teamwork between RN and aids
- Low HPPD correlated to higher missed nursing care
- Impacts LOS, pneumonia, falls, pressure ulcers, etc.

Piscotty R & Kalisch B. Nursing Management, 2014;144
Protect The Patient From Bad Things Happening on Your Watch

Implement Interventional Patient Hygiene
Interventional Patient Hygiene

- Hygiene...the science and practice of the establishment and maintenance of health
- Interventional Patient Hygiene....nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence based hygiene care strategies

Incontinence Associated Dermatitis Prevention Program
Achieving the Use of the Evidence

Factors Impacting the ability to Achieve Quality Nursing Outcomes at the Point of Care

Skills & Knowledge

Value

Attitude & Accountability

Resources & System

CNO’s

Vollman
KM. Intensive & Critical Care Nursing, 2013
Oct; 29(5): 250-5
Preventing NV-HAP Through Evidence Based Fundamental Nursing Care Strategies

Slides courtesy of Barbara Quinn
Oral Cavity & VAP

- 89 critically ill patients
- Examined microbial colonization of the oropharynx throughout ICU stay
- Used pulse field gel electrophoresis to compare chromosomal DNA
- Results:
  - Diagnosed 31 VAPs
  - 28 of 31 VAP’s the causative organism was identical via DNA analysis

- 49 elderly nursing home residents admitted to the hospital
- Examined baseline dental plaque scores & microorganism within dental plaque
- Used pulse field gel electrophoresis to compare chromosomal DNA
- Results:
  - 14/49 adults developed pneumonia
  - 10 of 14 pneumonias, the causative organism was identical via DNA analysis


El-Solh AA. Chest. 2004;126:1575-1582
Pathogenesis → Prevention

Germs in Mouth
- Dental plaque provides microhabitat
- Bacteria replicate 5X/24 hrs

Aspirated into Lungs
- Most common route
- 50% of healthy adults micro-aspirate in sleep

Weak Defenses
- Poor cough
- Immunosuppressed
- Multiple co-morbidities
Why NV-HAP?: DO NO HARM

- HAP 1st most common HAI in U.S.
  - Increased morbidity → 50% are not discharged back home
  - Increased mortality → 18%-29%
  - Extended LOS → 4-9 days
  - Increased Cost → $28K to $109K
  - 2x likely for readmission <30 day
- Understudied, under-addressed
- Focus has been on the other HAP → VAP
- Surveillance not required….yet

Kollef M.H. et.al. (2005). Chest. 128, 3854-3862
### NV-HAP SMCS Research Findings: 2010

#### Incidence:
- 115 adults
- 62% non-ICU
- 50% surgical
- Average age 66
- Common comorbidities:
  - CAD, COPD, DM, GERD
- Common Risk Factors:
  - Dependent for ADLs (80%)
  - CNS depressant meds (79%)

#### Cost:
- $4.6 million
- 23 lives
- Mean Extended LOS 9 days
- 1035 extra days

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Phase 1: Oral Care

- Formation of new quality team: Hospital-Acquired Pneumonia Prevention Initiative (HAPPI)
- New oral care protocol to include non-ventilated patients
- New oral care products and equipment for all patients
- Staff education and in-services on products
- Ongoing monitoring and measurement
  - Monthly audits

# Protocol – Plain & Simple

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Tools</th>
<th>Procedure</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Care / Assist</td>
<td>Brush, paste, rinse, moisturizer</td>
<td>Provide tools Brush 1-2 minutes Rinse</td>
<td>4 X / day</td>
</tr>
<tr>
<td>Dependent / Aspiration Risk</td>
<td>Suction toothbrush kit (4)</td>
<td>Package instructions</td>
<td>4 X / day</td>
</tr>
<tr>
<td>Dependent / Vent</td>
<td>ICU Suction toothbrush kit (6)</td>
<td>Package instructions</td>
<td>6 X / day</td>
</tr>
<tr>
<td>Dentures</td>
<td>Tools + Cleanser Adhesive</td>
<td>Remove dentures &amp; soak Brush gums, mouth Rinse</td>
<td>4X / day</td>
</tr>
</tbody>
</table>
Oral Care Frequency Per 24 Hours – All Units

X-bar chart mean oral care May, 2012 through December, 2013
(excludes months with < 10 cases)

Baseline

Mean Oral Care
Open Heart Surgery Patients:
NV-HAP Reduced 75%

Oral chlorhexidine periop started
NV-HAP Incidence
50 % Decrease from Baseline
Return on Investment

- 60 NV-HAP avoided Jan 1 – Dec. 31 2013
- $2,400,000 cost avoided
- $2,282,400 return on investment
- 8 lives saved

PRICELESS
NV-HAP 70% from baseline!

Control chart for non-ventilator HAP
January 2010 to December 2014

- Oral care for all adult pts
- Documentation
- NGT standards revised
- Pharmacy starts PPI protocol
- Started oral care prior to surgery
- Mandatory Education for Nurse Assistants
WHEN WOULD NOW BE A GOOD TIME TO DO THIS?

It is not enough to do your best; you must know what to do, and THEN do your best.

~ W. Edwards Deming
Evidence-Based Practice


• It takes as long as 17 years to translate research findings into practice (Balas & Boren, 2000, Managing clinical knowledge for healthcare improvements pp.65-70. Germany: Schattauer Publishing Co.)

• Without current best evidence, practice is rapidly outdated, often to the detriment of patients.
Evidence-Based Practice

Program overview:

Challenges Incorporating EBP into Practice

• Lack of training and critical appraisal of research evidence
• Lack of clinically relevant nursing research on a particular clinical topic
• Gap between available nursing research in the form of systematic reviews and use by nurses for direct patient care
• We are not connecting quality patient outcomes to EBN
• Lack of health care agencies organizational infrastructure to promote EBN practice
Organizational & Unit Structures that Supported Empowerment & Evidence Based Practice

- Shared Governance Model
- Professional Practice Model/Clinical Ladder
- Unit Based Leadership Model
- Educational Support
- Continuous Quality Improvement Model
Empowered Work Environment

System Role

Education Specialist

Unit Educator

Unit Medical Director

Patient/ & Bedside Family Nurse

Clinical Nurse Specialist

Nurse Manager

CNS System Role

Nurse Manager System Role

Unit Governance Council

Inpatient Unit
What is Good About EBP!!!

- Firm foundation to do the right thing
- Improved patient outcomes
- Basis for interventions
- Basis for evaluation
- Ability to talk in a similar language with other disciplines
- Methods allow correct and more expedient movement of evidence into practice
Activity without purpose is the drain of your resources
We Make a Difference in Quality & Safety

• Increase nurse staffing was associated with; lower hospital related mortality, lower cardiac arrest, lower hospital acquired pneumonia in the surgical population, lower episodes of failure to rescue, lower UTIs, lower G.I. bleed/shock, lower falls & rates in hospital acquired pressure ulcers

• The risk of hospital deaths would increase by 31% or roughly 20,000 avoidable deaths each year if all hospitals at eight patients per nurse instead of four (JAMA 2002)

• When nurses case managed children with asthma there were fewer absences from school

• 11% improvement in failure to rescue (HealthGrades 2009 Report)
We Make a Difference in Quality & Safety

- Home care/discharge planning/APRN’s; lower length of stay, lower healthcare costs, fewer hysterectomies
- Patient satisfaction directly correlated to registered nurse satisfaction (HCAHPS)
- 10% ↑ in the # of RNs ↓ lung collapsed by 1.5%, pressure ulcers 2%, Falls 3%, UTI < 1% (Urich Med Care 2003, 41(1):142-152)
- Nurses effect explained 7.9% of variance in patients clinical condition during their hospital stay (Yakusheva O, et al, HSR, 2014)
Patient Safety Strategies Strongly Encouraged for Adoption with Moderate to High Evidence

- Preoperative and anesthesia checklists to prevent perioperative events
- Bundles with a checklist to prevent CLA-BSI
- Interventions to reduce use of urinary catheters; stop orders, reminders or removal protocols
- Bundle to prevent ventilator associated pneumonia
- Hand hygiene
- Multiple component initiative to prevent pressure ulcers
- Prophylaxis intervention for venous thromboembolism
- Using real-time ultrasonography for placement of central catheters

Alspach JG. Crit Care Nurse, 2013;33(3):9-12
Patient Safety Strategies Encouraged for Adoption with Moderate to High Evidence

- Interventions to reduce patient falls
- Using clinical pharmacist to reduce adverse drug events
- Documenting patient preference for life-sustaining treatment
- Obtaining informed consent prior to medical procedures
- Team training
- Medication reconciliation
- Using surgical outcome report cards
- Rapid response systems
- Computerized provider order entry
- Using simulation training and patient safety efforts

Alspach JG. Crit Care Nurse, 2013;33(3):9-12
Team
There is no “I” in TEAM...but there is a “ME”
Path to High Performing Teams

- Team Leadership
- Mutual performance monitoring
- Backup behavior
- Adaptability
- Team orientation

Shared Mental Model

The leader directs & coordinates team activities
- Team members monitor each other's performance
- Team members anticipate & respond to one another's needs
- Team adjust strategies based on new information
- Prioritize team goals over individual goals

Closed Looped Communication


Mutual Trust
Effective communication amongst caregivers is essential for a functioning team.

The Joint Commission reports that ineffective communication is the most commonly cited cause for a sentinel event (70%).

Observations of ICU teams have shown errors in the ICU to be concentrated after communication events (shift change, handoffs, etc).

30% of errors are associated with communication between nurses and physicians.

Reader, CCM 2009 Vol 37 No 5; Donchin CCM 1995 Vol
Tools and Strategies to Improve Communication and Teamwork

- Structured Handoff
- Huddles
- Daily rounds/goals
- Pre-procedure briefing
- Checklists
Structured Handoffs/Clinical Handover

- Information Processing: Making sure the essential data are transferred for patient safety
- Structured face to face, structured tool, electronic sign outs
- Substandard or variable handoffs has contributed to errors, care omissions, treatment delays, inefficiencies from repeated work, inappropriate treatment, adverse events, increase length of stay, avoidable readmissions, an increase cost.
- 2013 ACHS NSQHS Standards measure to implement a standardized approach to communication during handoffs

ACHS NSQHE Standards
Huddles

- Enable teams to have frequent but short briefings so that they can stay informed, review work, make plans, and move ahead rapidly.
- Allow fuller participation of front-line staff and bedside caregivers, who often find it impossible to get away for the conventional hour-long improvement team meetings.
- They keep momentum going, as teams are able to meet more frequently.
Hospitals With High Teamwork Ratings

- Higher patient satisfaction
- Higher nurse retention rates
- Lower hospital costs

Tools Don’t Create Safety

People Do!!!

The Silent Treatment, April 2011
The Most Powerful Force of Human Behavior is Social Influence
“Setting an Example is Not the Main Means of Influencing Others….It is the Only Means”

Albert Einstein
Yes I Will
Yes I Will

Focus on Achieving Nurse Sensitive Outcomes & Commit to a Culture of Safety & Accountability
Yes I Will

Be the Power of One

“I am only one, but still I am one.
I cannot do everything, but still I can do something.
I will not refuse to do the something I can do.”

Helen Keller
“You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You must do the thing which you think you cannot do.”

Eleanor Roosevelt
Change and growth take place when a person has risked himself & dares to become involved with experimenting with his own life

Herbert Otto
Be the Innovation for Driving Change in Nursing Quality and Patient Safety
Questions?

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