Massachusetts Organization of Nurse Executives

Research Committee

Fall 2008 Posters

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Evaluation of Implementation of the *AORN Correct Site Surgery Tool Kit* and the Universal Protocol for Wrong Site Surgery

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Background: The *Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery* was developed by the Joint Commission and included in their guidelines for accreditation of healthcare organizations beginning on July 1, 2004. To standardize implementation of this protocol, the *Correct Site Surgery Tool Kit* was developed by the Association of periOperative Registered Nurses.

Objective: This study was undertaken to evaluate the effect of *Correct Site Surgery Tool Kit* on implementation of the Universal Protocol and to determine if there was a change in the incidence of wrong site surgery and near misses from January 2001 to July 2006. The Conceptual Model of Nursing and Health Policy served as the organizing framework.

Methods: Two national mailed surveys were conducted. A random sample of 800 registered nurse members from the Association of periOperative Registered Nurses completed the first survey. A stratified random sample of 800 acute care hospitals from the American Hospital Association database received the second survey. Non-respondents were encouraged to participate through postcard and telephone reminders. Response rates for the registered nurses survey were 65% (n = 519); for the hospital respondents 40.8% (n = 325).

Results: An overwhelming majority, (n = 390; 91.8%) of registered nurses and close to three quarters (n = 298; 73%) of the hospital respondents found the *Correct Site Surgery Tool Kit* helpful. More than 68% (n = 384) of registered nurses stated they had changed their practice after receiving the tool kit. The reported rate of wrong site surgery per 100,000 surgeries peaked in 2004 (4.27), with declining rates in 2005 (3.67) and 2006 (3.14). Respondents who had accessible near miss data (n = 91; 28%) indicated that the elements in the Universal Protocol were detecting system flaws that could have potentially led to a wrong site surgery.

Conclusion: Results indicate that the Universal Protocol is being accepted and implemented in surgical settings. The findings suggest that increased clarity and specificity of the language in the protocol will enhance its effectiveness. Multi-modal educational and outreach efforts, such as the tool kit, can influence practice changes in the clinical setting.

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Exploring Critical Thinking and Delegation in Nursing Practice

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Purpose-The aim of this descriptive study was to gain a greater understanding of how nurses use critical thinking to delegate nursing care.

Significance/Problem- In addition to knowledge and technical skills, nurses need to be able to synthesize large amounts of information and think through complex and often emergent clinical situations to make critical decisions about patient care, including the delegation of some aspects of care to other registered nurses and unlicensed personnel. This requires nurses to possess essential skills, including the cognitive process of critical thinking. Critical thinking is frequently discussed in practice with educators and clinical leaders agreeing that developing the ability to think critically is fundamental to nursing practice in these constraining times (Bittner,2001, Bittner & Tobin,1998). Currently, there is no research linking critical thinking to delegation.

Methodology-This study utilized focus group method with 27 medical surgical nurses at a single teaching hospital. The focus group interviews were audio taped and then transcribed verbatim into text documents. The participants were asked to describe clinical scenarios (without identifying patients, information or colleague information) in which they have been involved regarding delegation. The participants were specifically encouraged to describe the thinking process of delegation in these scenarios. The independent content analysis involves analyzing each session independently initially and then comparing cases once all are completed. The data from the full (not abridged) transcripts were reviewed, summarized and then coded by identifying idea clusters (Beyea & Nicoll 2000). The idea clusters led to the generation of a list of key themes.

Results-In the findings, nurses reported that they had a varying sense of confidence with delegation. They were able to articulate the thought process they use regarding delegation indicating that they consider patient condition, competency and experience of the nursing assistant (NA), as well as the workload. These findings are consistent with the literature regarding critical thinking includes knowledge, reasoning, reflection and judgment. Nurses shared they had specific knowledge expectations for the NA that included their ability to report significant findings, follow up of tasks, and competencies and assessment skills, as well as prioritizing skills that are not within the scope of practice for a NA. Successful delegation was dependent upon several factors including the relationship between the RN and the NA, communication, system support and nursing leadership. An important finding was that nurses reported instances of missed or omitted care.

Conclusions- This research and other research investigating what nurses' practice entail are important for validating the unique nature of practice. This type of research encourages nurses to think about their individual practice, specifically delegation. This is supported in the literature as foundational to critical thinking regarding professional practice. By encouraging nurses to self-examine their ways of thinking and delegating in practice, nurses experience a sense of heightened awareness that may not have previously been there. These findings also provide insight into factors affecting successful delegation for the basis of future research.

Implications- Future research would include investigation into the outcomes of unsuccessful delegation. In addition, research on the delegation process including planning, monitoring, supervision and evaluation in relation to omitted care is recommended. Kalisch (2006) has delineated elements of care that are routinely missed, six of which are delegatable tasks. This led to a subsequent quantitative study utilizing the Missed Care survey designed by Kalisch (2007).

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Lessons from State Roll-Outs of the NQF Nursing Sensitive Measures: Results from Stakeholder Interviews and Case Studies

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Research Aim: We conducted a study to better understand the development and early experiences with the novel, statewide programs recently proposed in Massachusetts and Maine for the public reporting of nursing sensitive performance measures endorsed by the National Quality Forum (NQF).

Methods: In 2006-2007 the research team conducted in-depth interviews with individuals in Massachusetts and Maine who were either involved in the development of their state's nurse sensitive measure (NSM) program or were important stakeholders. Stakeholders included leadership of each state's hospital associations, nurse executive associations, state quality organizations, nursing unions, key hospital leaders (CEOs and CNOs) and executives from payers. Interviewees were asked about the context of the NSM program, barriers and facilitators to its development. In addition we conducted hospital case studies at 3 hospitals in Massachusetts and 3 hospitals in Maine of varying size and location. Case studies focused on barriers and facilitators to the implementation of the measures and early experiences with the program, including expected impact on quality related activities. Case study interviews focused on directors of quality and nursing, hospital staff involved in performance measurement and analysis, and front-line nurses.

Results: Both states were able to implement programs for the public reporting of NSMs. A key lever for their development was discussion in both states about nurse staffing and its relationship to quality. While the NQF's endorsement of a set of nurse sensitive measures facilitated the programs' development, only a subset of the NQF measures were selected for reporting in both states. Many of those interviewed expressed concerns about the validity of the measures and comparisons of NSMs across hospitals. Voluntary programs may be more likely to facilitate a consensus on the measurement program while mandatory programs may be more likely to move controversial measures forward.

Conclusions: Statewide programs for public reporting of NSMs are possible.

Implications for policy, delivery, or practice: The impact of NSM public reporting programs on nurse staffing, nursing quality, and overall hospital performance, as well as the extent to which consumers make use of the data, remains to be seen. The Massachusetts and Maine experience provides a foundation from which hospitals and states can learn as they contemplate public reporting of nursing sensitive measures.

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Neonatal Abstinence Syndrome (NAS): Developing a Standardized Approach to Care

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Purpose or Aim: A standardized approach to the medical management and nursing care of neonates exposed to maternal substance abuse.

Background: The AAP (1998) and Marcellus (2007) recommend a comprehensive medical and psychological history be obtained prenatally for maternal drug use for the early identification of newborns that have been exposed to substance abuse. Newborns can exhibit behaviors that require initiating management sooner reducing adverse events as well as decreasing the length of stay. Drug withdrawal should be considered as a diagnosis when infants exhibit any behaviors associated with possible exposure.

Setting/Population: The Parent/Child Division of South Shore Hospital has 4000 deliveries per year and consists of maternal fetal medicine, a birthing unit, a maternal-infant unit, a neonatal intensive care and a pediatric unit.

Methodology/Process: A literature search was conducted for best practices. Staff assessments and retrospective chart reviews demonstrated inconsistencies in practice. A learning module was developed and distributed throughout the division.

Outcome Measures

- Staff knowledge of the pathophysiology of NAS and the application of the Finnegan Tool was evaluated
- Retrospective chart reviews were conducted for compliance with protocol use
- Community understanding of NAS

Results

- Modular testing scores ranged from 62.5% to 100% with a mean score of 81.2%.
- Retrospective audits from February through June showed 6 neonates received pharmacologic treatment for NAS per protocol.
- There was 100% compliance with the use of the new protocol.

Lessons Learned

The use of evidence safeguards and promotes the highest standard of care, establishing sound credibility of effective nursing practice.

Practice Implications

- Identification and parental education prior to admission
- Consistent communication and documentation
- Criteria for transfer to other units
- Improved collaboration among healthcare providers
- Improved treatment protocol

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Relationship-Based Care Model Implementation

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Purpose
Improve the overall culture and environment of Fairview Hospital by creating therapeutic relationships between patients, family and staff. The model provided a framework for increasing patient satisfaction, improving communication and ensuring a holistic environment.

Background
Fairview already manifests some of the principles of the Relationship-Based Care model (RBC). The model provides both a philosophical foundation and a practical infrastructure to achieve organization-wide transformation. Adapting the RBC model would expand the Magnet journey already in progress.

Setting/Population
The model has been modified and adapted to include all employees.

Methodology/Process
Two selected staff members, who embodied the principles of the model, were sent to a program with the authors and editors of RBC. Upon their return, education was given at staff and council meetings. The sessions defined the model, explained the purpose and clarified the expectations of staff. Examples of the evidence of RBC principles already being manifested were shared. During those sessions, a pre-implementation survey was administered. Survey revealed that 90% of the people responding admit that they do not speak directly and promptly to persons with whom they have conflict. Reinforcement of the model included re-education in resistive departments, facilitation of conflict intra-departmentally and solicitation of feedback through rounds. Utilization of posters, buttons and affirmative quotes were introduced as another means of re-enforcement.

Outcome Measures/Results
The mean overall Press-Ganey score from 10/1/07-12/311/07 was 90.8 and from 1/1/08-3/31/08 improved to 91.1.

Lessons Learned
Staff were more willing to support others as indicated by increased cross-training. People are willing to change when inspired, have essential education to support the change and when they see evidence of success. Supported staff results in better care for the patient. All must participate (administration, physicians) to succeed.

Practice Implications
Hospitalists and nurses worked together to facilitate smooth transfer of patients between departments Time with patients has increased. Foot massages with aromatherapy and Reike were offered to patients as part of their daily care. Collaborative decision-making is regularly practiced at all levels.

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Therapeutic Hypothermia after Cardiac Arrest

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Purpose: To improve the neurological outcomes and mortality of patients with cardiac arrest who remain comatose after the return of spontaneous circulation with induced hypothermia for 24 hours.

Description: After reviewing evidence-based practice articles a statement of policy was implemented for successfully resuscitated cardiac arrest comatose patients in order to improve outcomes. Cardiac arrest with widespread cerebral ischemia can lead to severe neurological impairment. Clinically induced therapeutic hypothermia has been shown to improve the neurological recovery and outcomes after Ventricular Fibrillation or Ventricular Tachycardia arrest. The goal of therapeutic hypothermia is to achieve a core temperature of 32-34 degrees Celsius and maintain that level for 24 hours and re-warm the patient slowly to avoid complications. Intensive bedside critical care nursing is needed to administer sedatives, analgesics and neuromuscular blockade agents to achieve moderate to deep sedation levels to promote mechanical ventilation and prevent shivering. Temperature and vital signs are monitored every 30 minutes until target temperature is achieved, then hourly monitoring for the duration of therapy. Continuous monitoring of cardiac arrhythmias, electrolyte imbalances and skin care assessments are done every hour to prevent complications. Emotional support and ongoing education assists family members of patients to understand the process and provide hope during a stressful and critical situation.

Evaluation/Outcomes: A small group of patients were evaluated after implementation of therapeutic hypothermia. A standard physician order set was approved to implement therapeutic hypothermia and re-warming after cardiac arrest. Based on these outcomes, increased awareness through education and communication were discussed with multidisciplinary team members in order to consider therapeutic hypothermia in all cardiac arrests. The 2005 AHA ACLS guidelines support the benefits of cooling patients to preserve neurological integrity.

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