Restructuring Clinical Experiences

SREB Council on Collegiate Education for Nursing
November 17-19, 2013 Atlanta GA

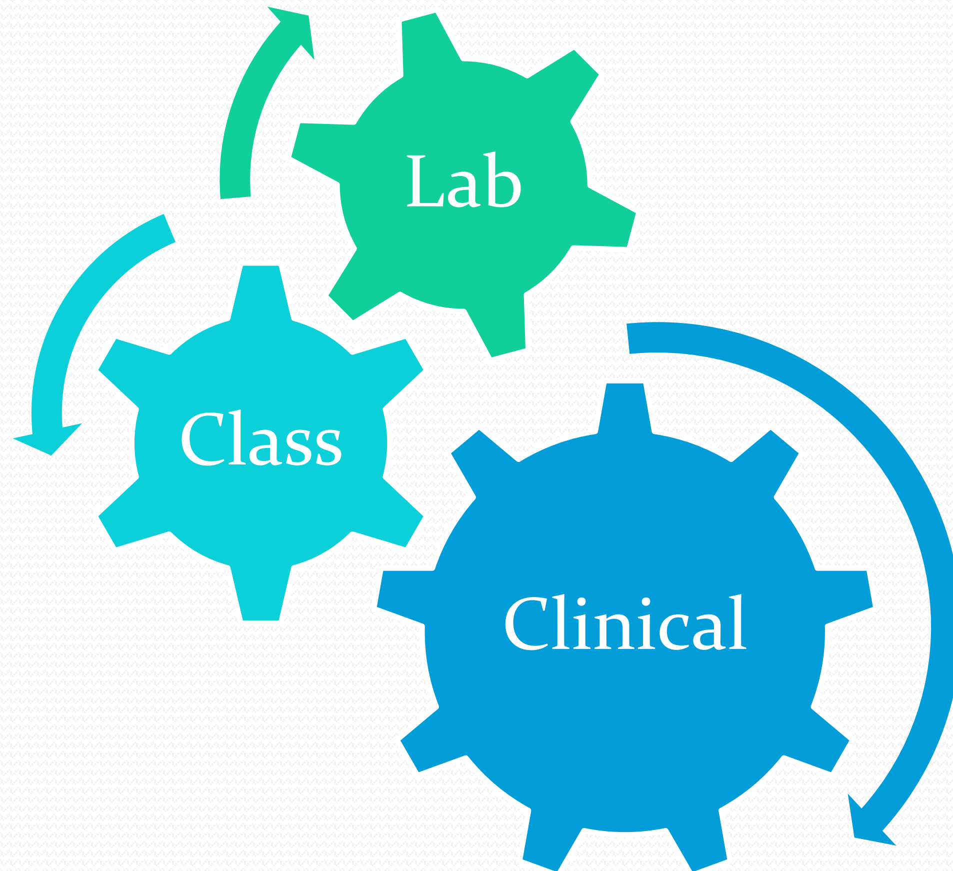
Carol F. Durham EdD RN ANEF, FAAN
Clinical Professor
Director, Education-Innovation-Simulation Learning Environment
School of Nursing, The University of North Carolina at Chapel Hill
President, International Nursing Association for Clinical Simulation and Learning (INACSL)

Think – Pair - Share

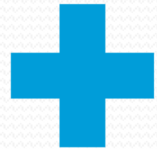
- Reflect on your first day of clinical as a student
  - What were you thinking?
  - What were you most concerned about?

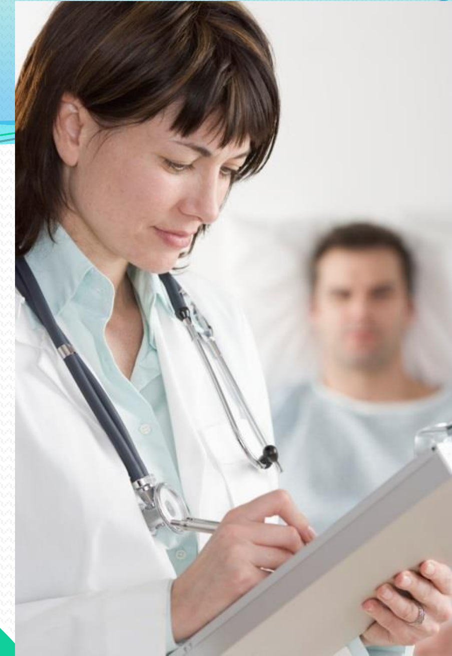
- Reflect on your first day of clinical as clinical faculty
  - What were you thinking?
  - What were you most concerned about?

Tripartite



Our Focus

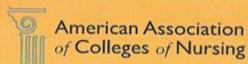


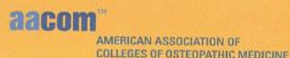


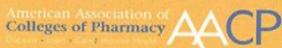
Institute of Medicine Health Professions Education Framework

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

Committee on Health Professions Education Institute of Medicine (2003)



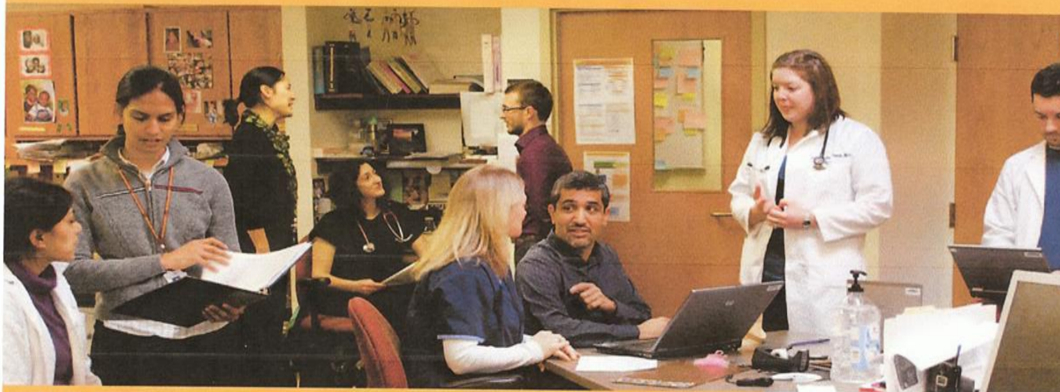




Tomorrow's Doctors, Tomorrow's Cures®

Core Competencies for Interprofessional Collaborative Practice

Sponsored by the Interprofessional Education Collaborative*



Report of an Expert Panel

May 2011

*IPEC sponsors:

American Association of Colleges of Nursing

American Association of Colleges of Osteopathic Medicine

American Association of Colleges of Pharmacy

American Dental Education Association

Association of American Medical Colleges

Association of Schools of Public Health

http://www.aacn.nche.edu/education-resources/ipecreport.pdf

Patient Safety

- What is the issue?
  - 20% chance of dying from adverse event
  - of 270,491 deaths, 238,337 were potentially preventable (2004-2006) [only 32,145 were not]
  - 1999 IOM report 100,000 deaths annually
    - 273 per day
    - 11 per hour
    - 1 every five minutes
    - OR one - two 747 crash each day for a year
  - 400,000+ medication errors per year
  - $8-29 billion spent annually

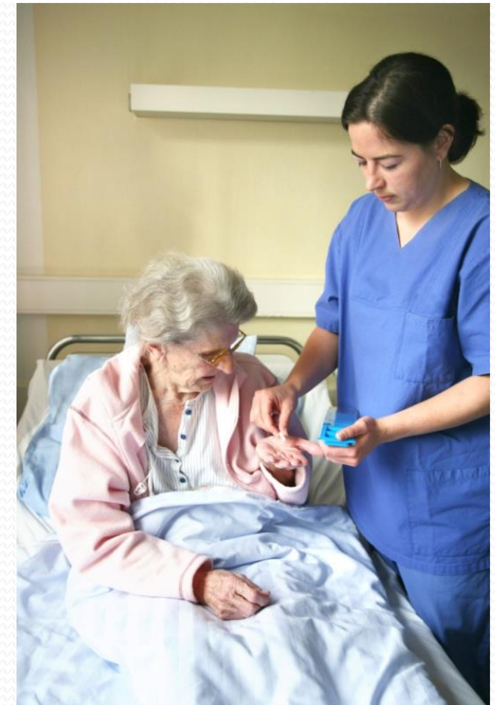
Lecture *alone* will not create the behavior change required

Knowing

We expect our learners to go beyond ***learning*** knowledge . . .

to ***application*** of the knowledge.

Doing



- Goethe

Creating meaningful learning experiences

"What is essential for nursing [interprofessional] 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.

Welcome to Today's Briefing

- You are an employee of the
  Visual Impact Advertising Agency
- Review recently received *rough* draft of the flyer for an upcoming event

Instructions

- Select a partner with whom to discuss the poster design.
- Decide who will be partner A and who will be partner B
- Take 1 minute to look at the picture
- **Do not dwell on the picture. Look at it only long enough to "take it all in" once.**
- Make a mental note of the items you see in the picture

Group A CLOSE your eyes

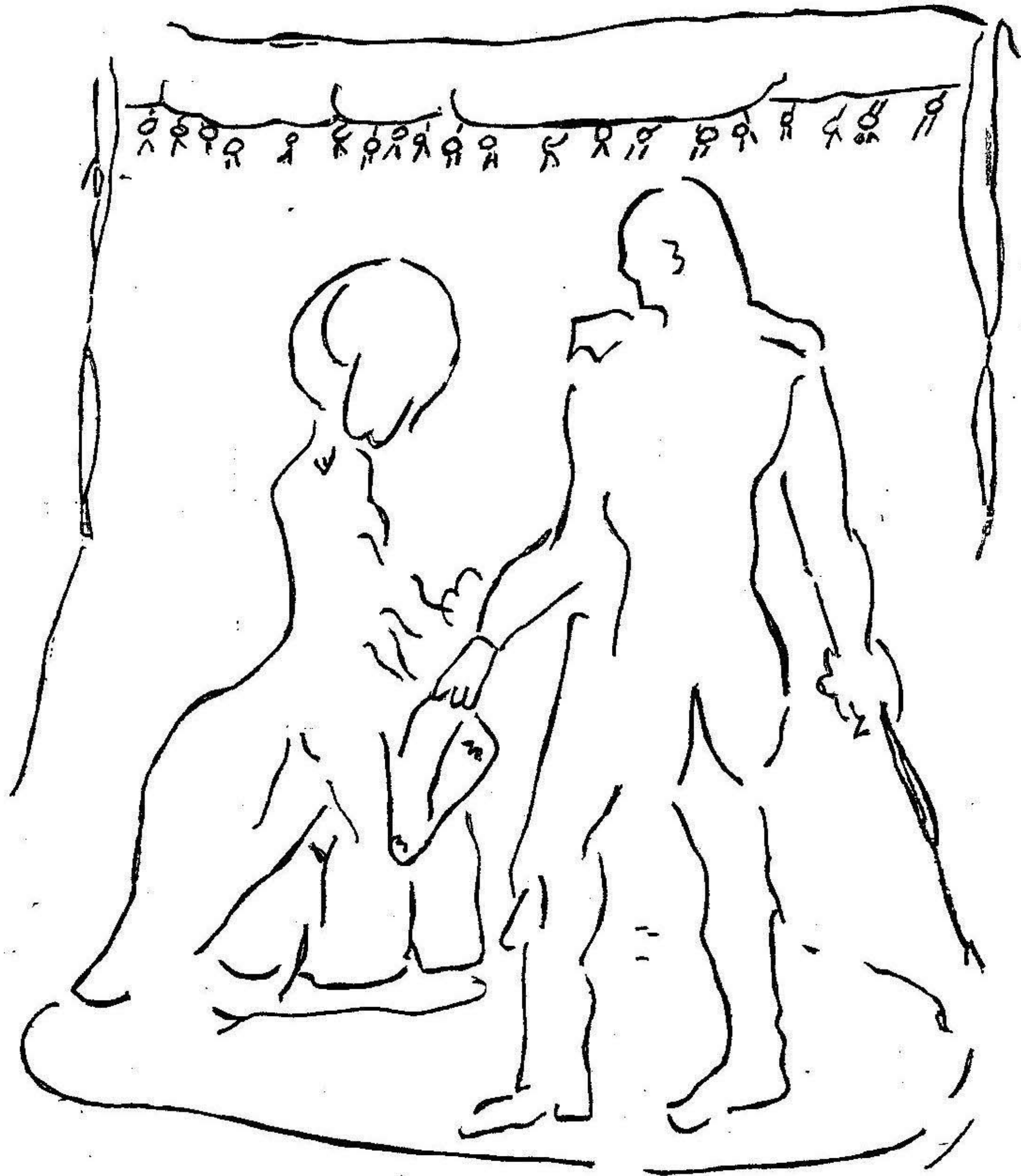
Group B – the poster is for

ball room dancing

Group B CLOSE your eyes

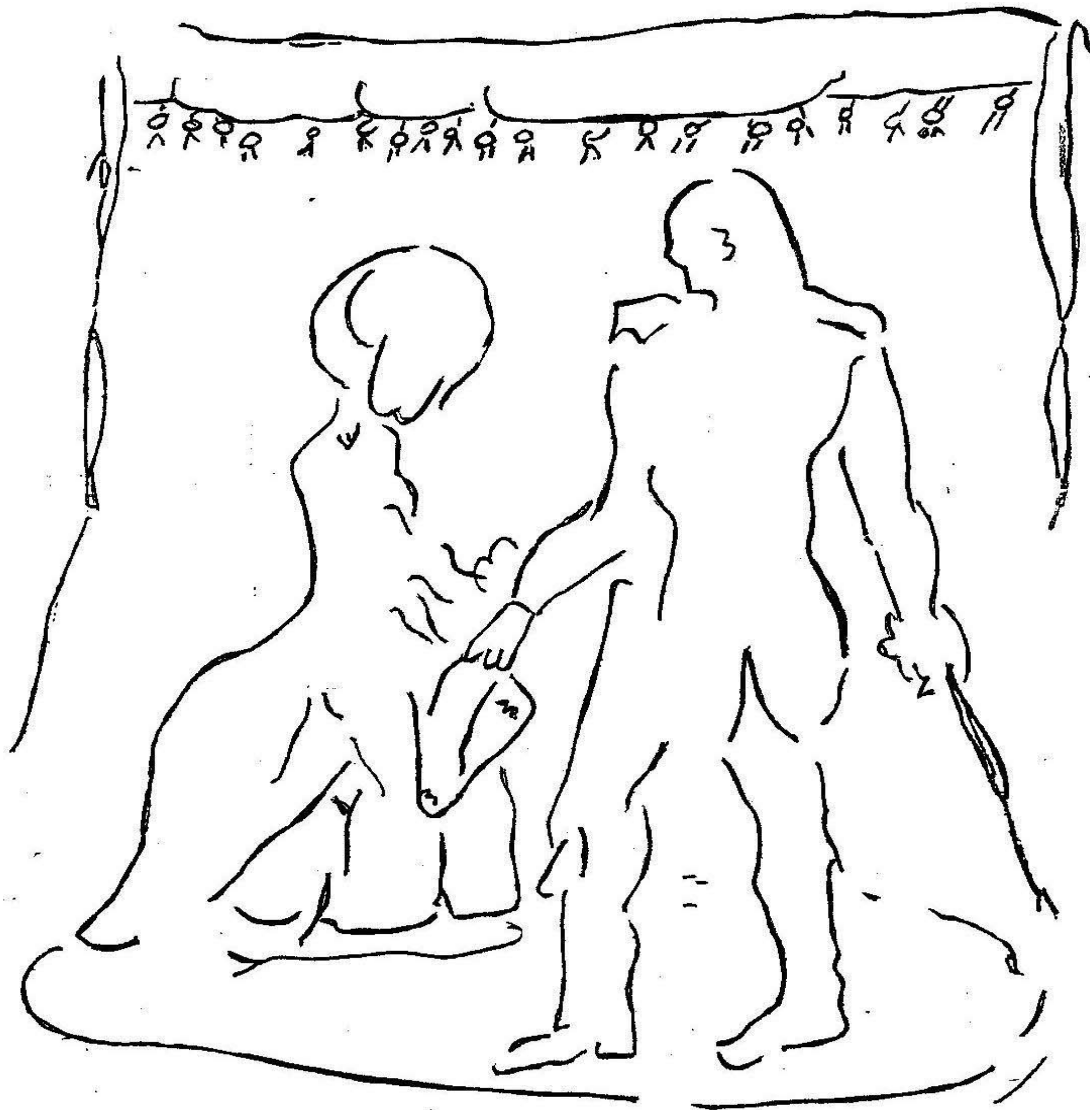
Group A – open your eyes the poster is for

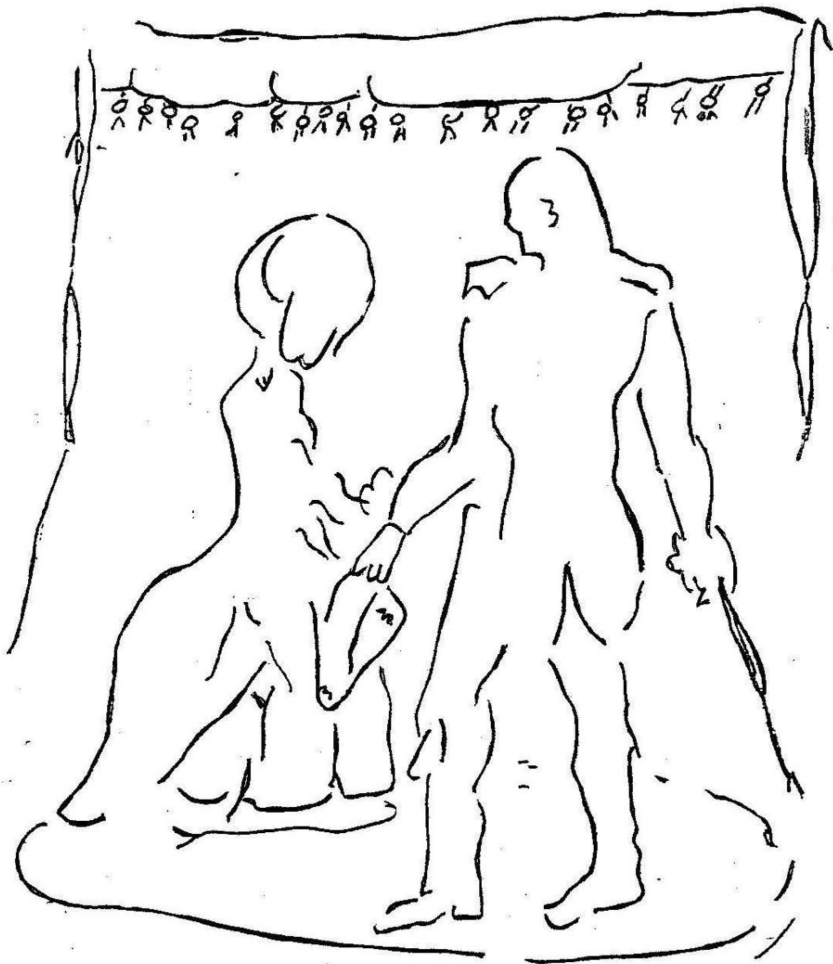
a circus act



Communication Exercise

- Take 45 seconds each to share what you saw with the person next to you
  - Discuss similar and different views





Did you see a …

man?
woman?
animal?
whip?
sword?
man's hat?
ball?
fish?

QSEN Competencies
Patient-centered Care
Teamwork & Collaboration
http://qsen.org/communication-picture-exercise/

Restructuring Clinical Experiences

- Why?
- What?
  - Co-create a spirit of inquiry
  - Share vigilance around patient safety
  - Model collegiality within psychologically safe environment
- How?
  - Clinical Faculty fully deployed keeping patient(s) safe while teaching
  - Tweak what doing to make connections without piling on more to do

Engaging learners with questions

What stands out?

What are you concerned about for the patient?

What action will you take? Why? What else could it be?

Talk ***out loud*** about the safety surveillance you do automatically. Model what you want to see.

Patient Presentations

Use safety tools/language such as briefings, huddles, checklist, SBAR

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

SBAR

- Situation
  - I am taking care of . . .
  - I have just assessed her/him and vital signs , etc. are
- Background
  - Brief history
- Assessment
  - This is what I think is going on . . .
  - I am concerned about . . .
- Recommendation
  - My plan of care is . . .
  - My patient has the following today . . .
  - I have questions about . . .
  - I would like to have your assistance with . . .

Effective Teamwork in Action +++

January 15, 2009 US Airway Flight 1549

Learn from mistakes

- Discuss near misses
- Talk about errors that have happened
- Use AHRQ M&M to build simulated learning events or discuss in post conference
- Use real cases to illustrate how easy it is to make a mistake
  - Individual
  - System issues

Read this?!

- Icdnuolt blveiee taht I cluod aulaclty uesdnatnrd waht I was rdgnieg. The phaonmneal pweor of the hmuan mnid aoccdrnig to rscheearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, the olny iprmoatnt tihng is taht the frist and lsat ltteer be in the rghit pclae. The rset can be a taotl mses and you can sitll raed it wouthit a porbelm. Tihs is bcuseae the huamn mnid deos not raed ervery lteter by istlef, but the wrod as a wlohe.

Amzanig huh?

10
units/ml

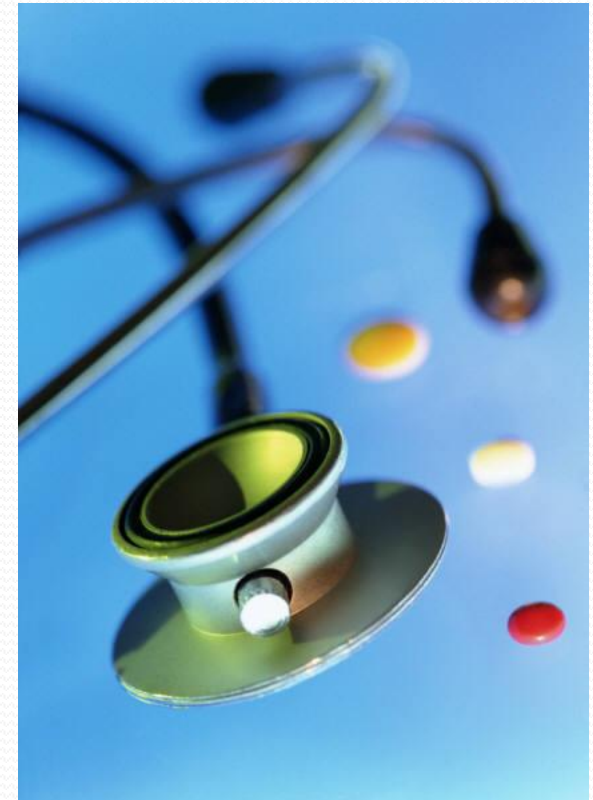
100
units/ml

1,000
units/ml

10,000
units/ml

Pharmacology Competency

- Teach nursing content in silos as well
  - Pharmacology
  - Medication administration
- Competency exam students have to apply both within a timed test – focus on:
  - Patient-centered Care
  - Teamwork and Collaboration
  - Evidenced-based Practice
  - Safety (If make medication error in any of the competency exams has to complete variance report)



QSEN

QSEN INSTITUTE

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QSEN Institute

Comprehensive, competency based resources to empower nurses with knowledge, skills, & attitudes to improve quality & safety across healthcare system

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NEWS

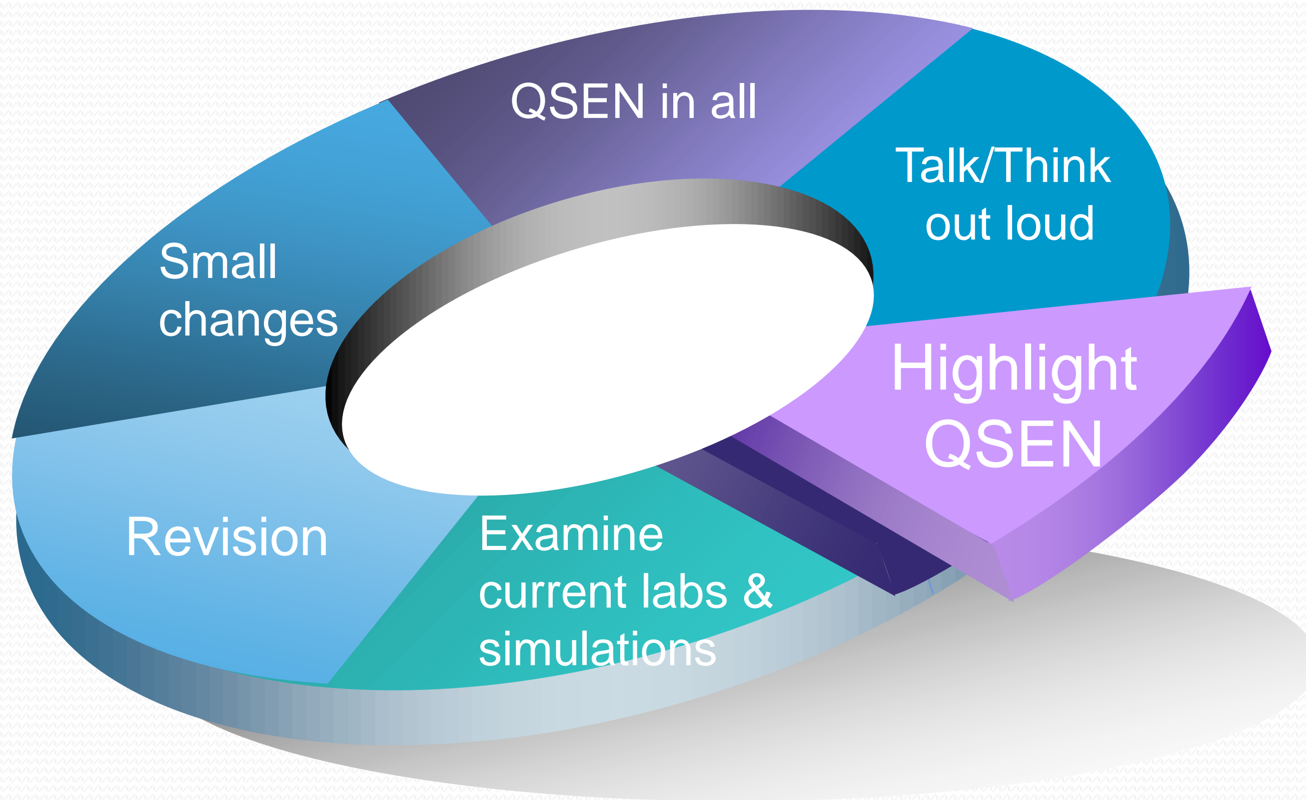
MORE POSTS »

OCT 21

SEP 06

SEP 05

Integrating QSEN Competencies



Enhancing Safety Awareness

Quality & Safety Monitor

- Author: Laurie Palmer
- http://qsen.org/quality-and-safety-monitor-assignment-2/

Staff Workarounds

- Author: Lisa Day
- http://qsen.org/staff-work-arounds-assignment/

Quality and Safety Monitor – Laurie Palmer

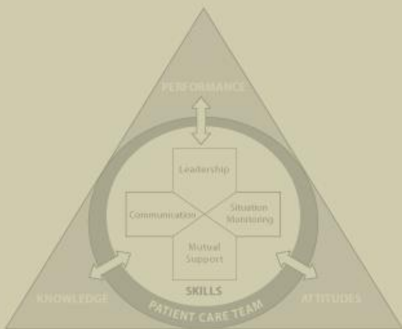
- Each week one student assigned role of Quality & Safety Monitor
- Use a checklist to assess all the student assigned students
- Include patient
- Collaborate with fellow student to discuss safety concerns
- Patient teaching around safety
- Report given at post-conference

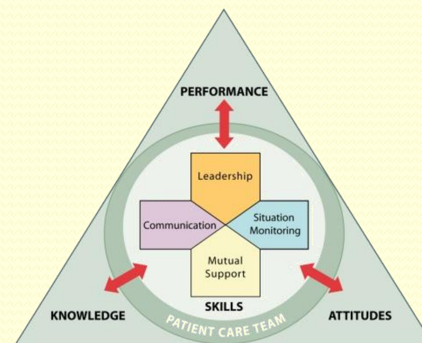
http://qsen.org/quality-and-safety-monitor-assignment-2/

Staff Workarounds - Lisa Day

- Choose a nursing policy or procedure
- Find the policy (was it easy to locate)
- Do RNs on unit know where it is – how initially disseminated
- Is policy EBP? Review current standards from professional organizations
- Observe RNs and students in performing chosen policy – note deviations, why deviations
- Discuss why RN might deviate from policy – consider challenges
- Discuss proper response when discover unsafe practice

http://qsen.org/staff-work-arounds-assignment/





TeamSTEPPS

Strategies and Tools
to Enhance Performance
and Patient Safety

PATIENT SAFETY

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

http://teamstepps.ahrq.gov/

Two-Challenge Rule

Invoked when an initial assertion is ignored…

It is your *responsibility* to assertively voice your concern at least *two times* to ensure that it has been heard

The member being challenged must acknowledge

If the outcome is still not acceptable

- Take a stronger course of action
- Use supervisor or chain of command

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care · www.ahrq.gov
PATIENT SAFETY

http://teamstepps.ahrq.gov/

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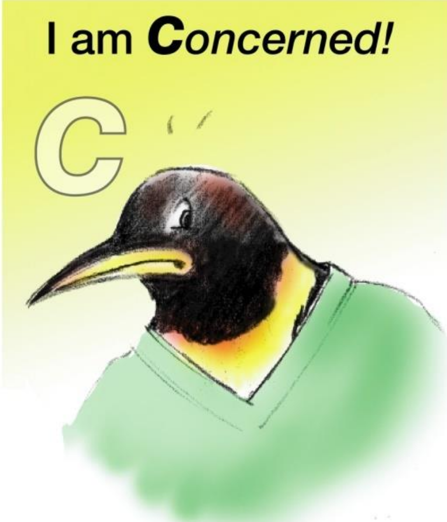
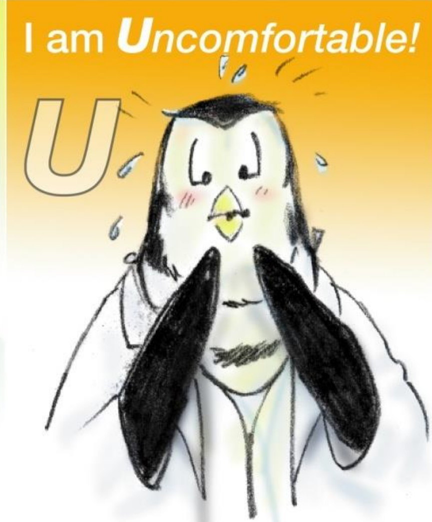
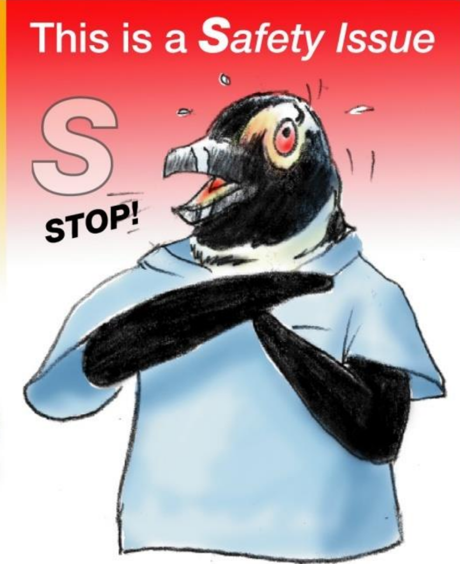






Please Use CUS Words

but *only* when appropriate!

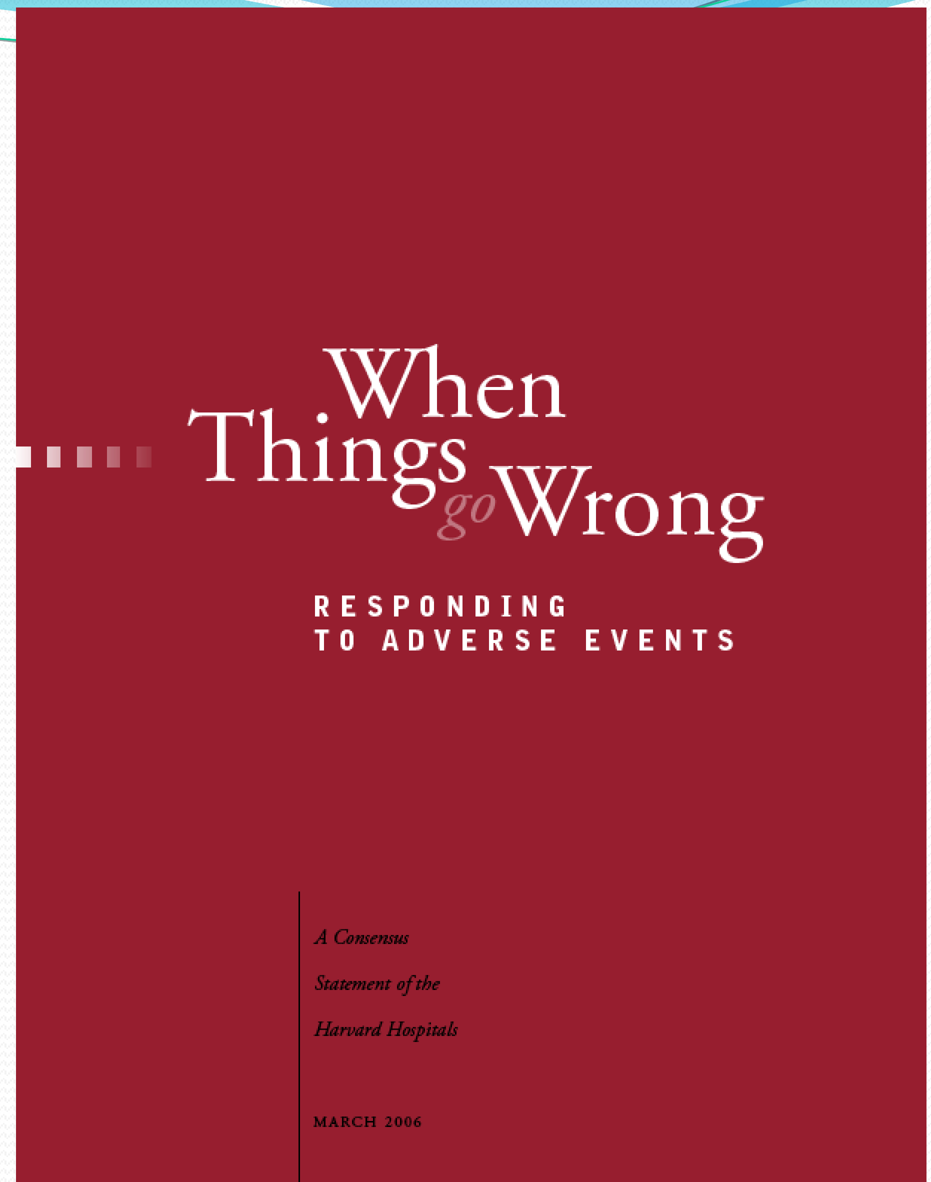
Just Culture demonstrated

- Teaching Assistant made an error - distributed expired saline to students for administration
- This strategy can enhance students understanding of near misses or mistakes.

Quality Improvement

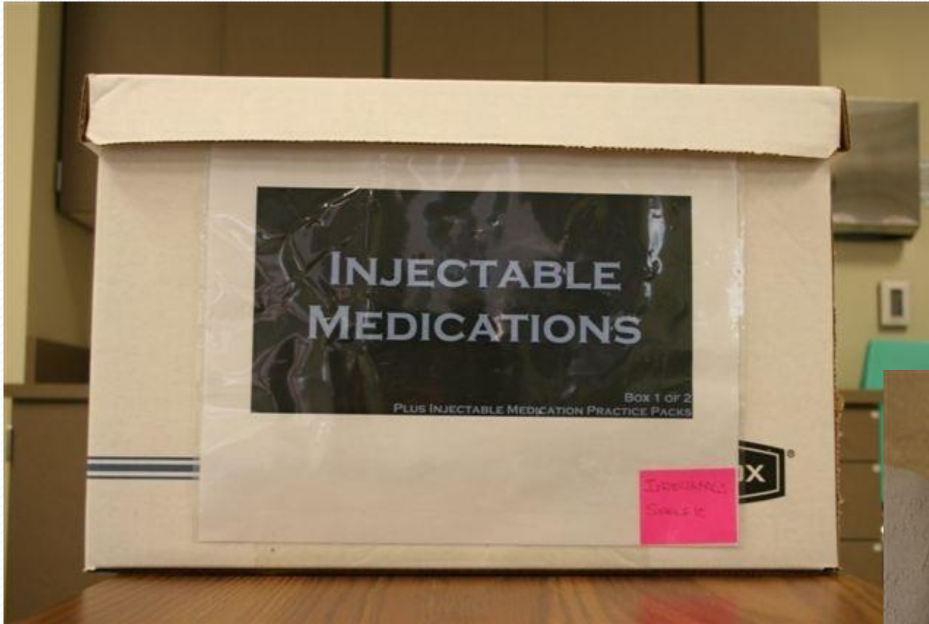
Just Culture in **ACTION**

- Injection lab
- Error made . . .
- *Walk the Talk*



http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/WhenThingsGoWrongRespondingtoAdverseEvents.htm

Teaching Box



Error Disclosure

- Teaching Assistant to Lab Director
- Director to Infectious Disease and Supervisors
- Teaching Assistant to Students

Root cause analysis

- Data Collection
- Casual factor analysis
- Root cause identification
- Recommendation generation
- Implementation

EXEL
HYPODERMIC
DISPOSABLE
STERILE IN-DATE
SUPPLIES FOR
STUDENT
INJECTIONS
INJECTABLE
MEDICATIONS

INJECTABLE MEDICATIONS

Sterile Injection Supply Expiration Dates

1 ml syringe	05/2012
Eclipse Safety Needle	12/2011
30 ml 0.9 NaCl	9/1/2009

INJECTABLE MEDICATIONS

STERILE IN-DATE SUPPLIES FOR STUDENT INJECTIONS

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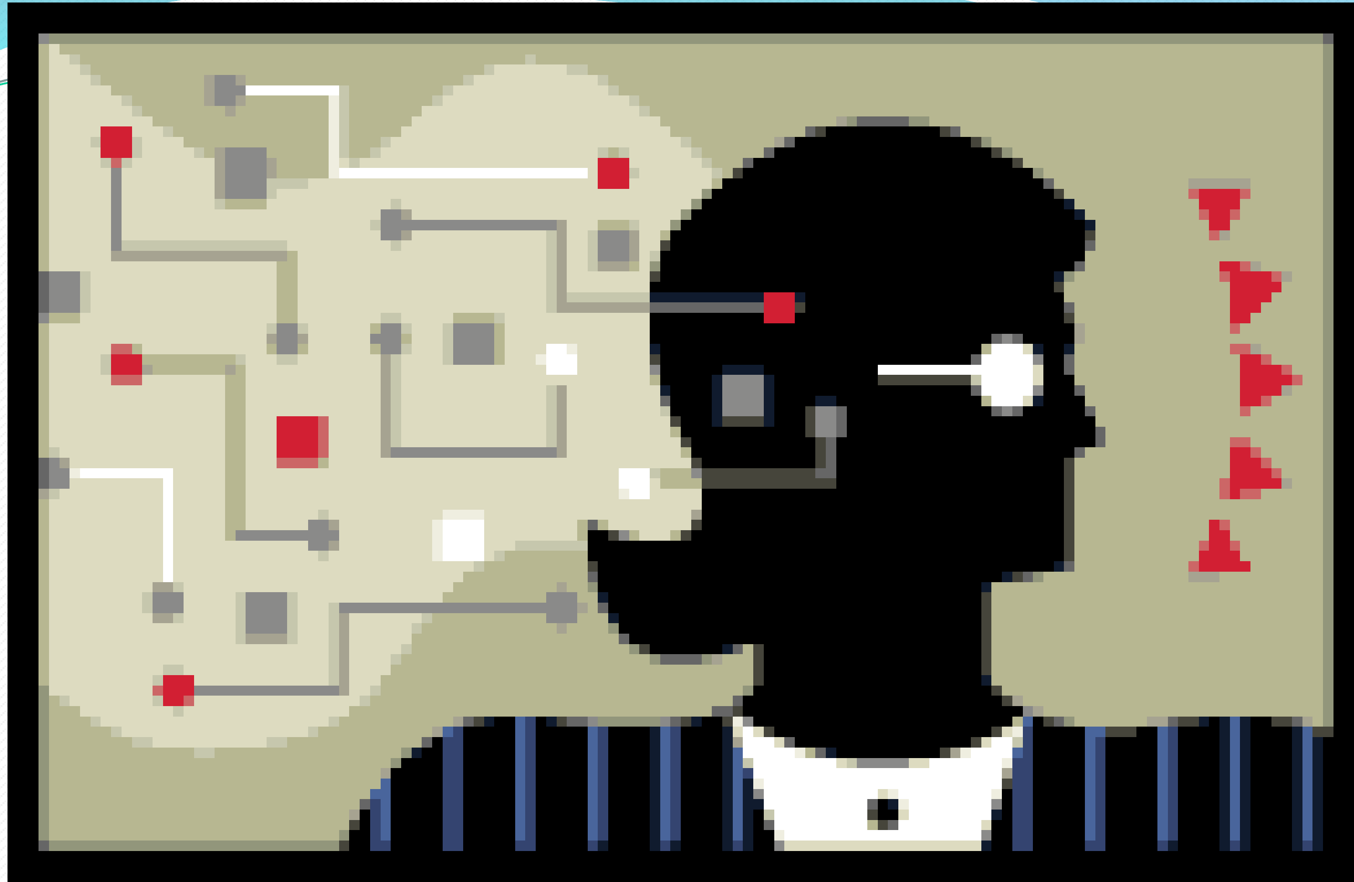


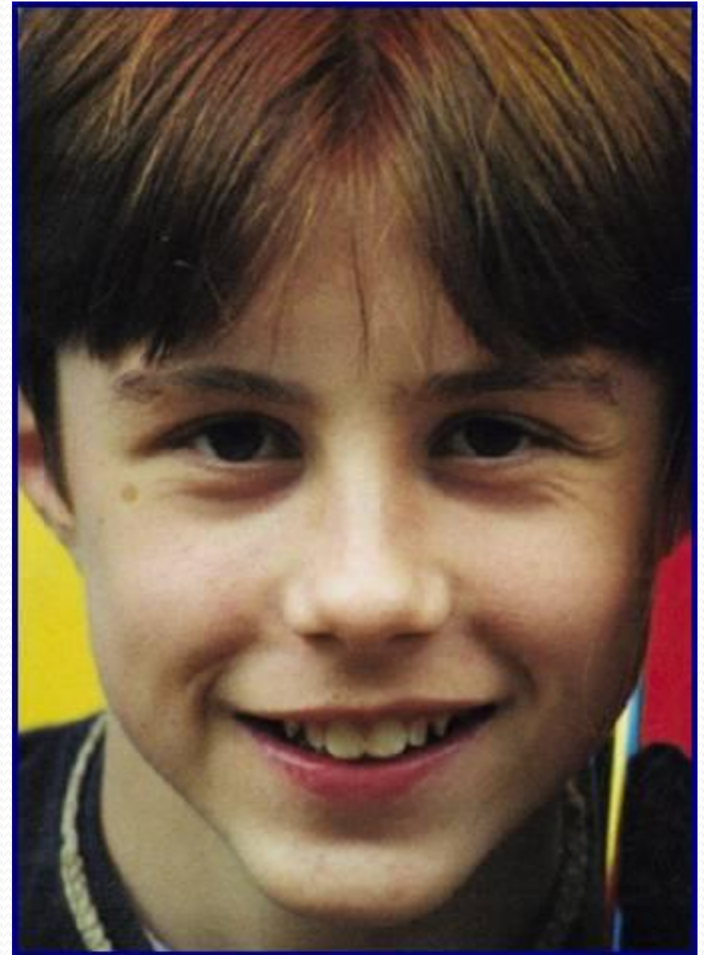
Structured simulations encourage students to think as opposed to memorize.

Olesinski, R. (1998)

The Story of Lewis Blackman

Transparent Health®, 2009

- Putting faces with Medical Error
- Chronicles the care trajectory of a vibrant, gifted, healthy 15-year-old boy who entered the hospital for what was believed to be a low-risk elective surgery and who died ***100 hours*** later due to medical errors.
- Let's consider Lewis' story



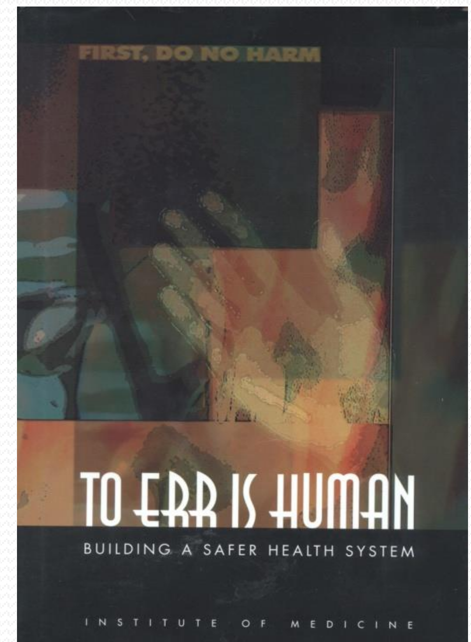
http://www.transparentlearning.com/

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

Helen Haskill, mother

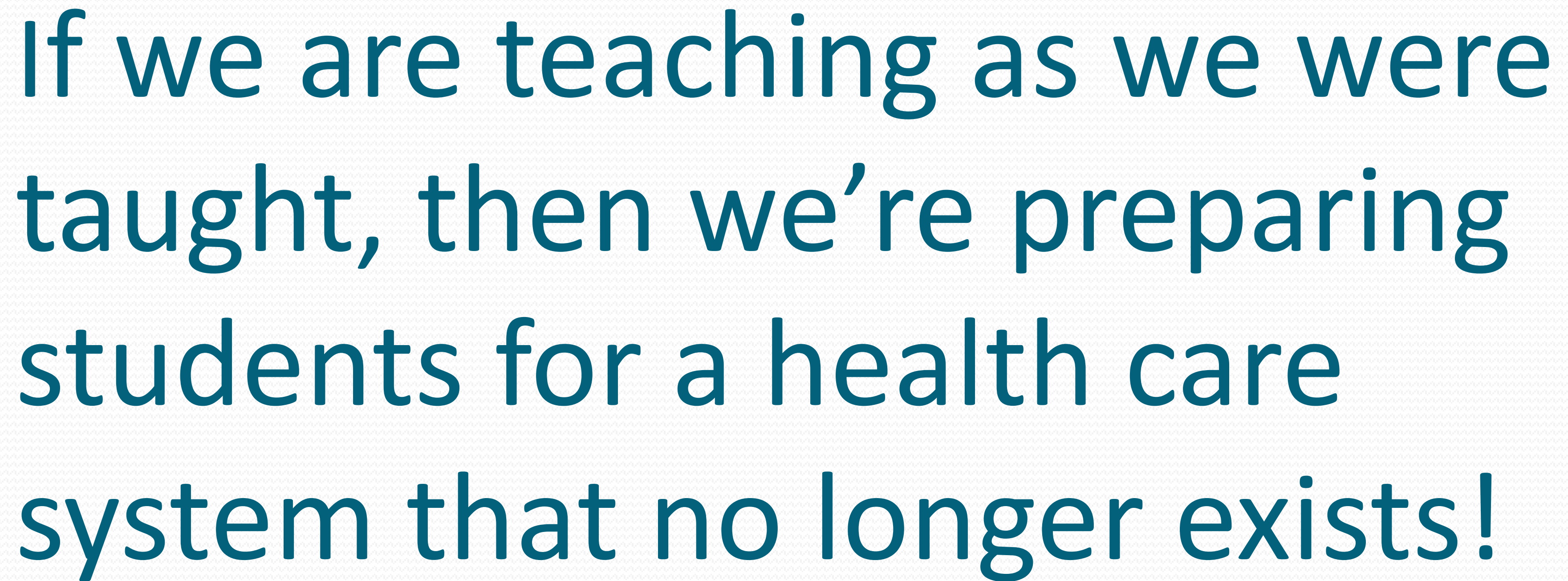
To Err is Human

"It is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort"



Transforming Healthcare

Professional knowledge	Systems Knowledge
Individual Learning	Team Learning
Blame Individual	Just Culture
Discipline focus	Interprofessional focus



Diekelmann, 2002; NLN, 2003; Oesterle & O'Callaghan, 1996; Porter- O'Grady, 2003

Contact Information

Carol F. Durham EdD, RN, ANEF, FAAN

Clinical Professor

Director, Education-Innovation-Simulation

Learning Environment

School of Nursing

University of North Carolina at Chapel Hill

cdurham@email.unc.edu

President, International Nursing Association

for Clinical Simulation and Learning

NC Board of Nursing

Information Crystal Harris mentioned

Just Culture Information

- http://www.ncbon.com/dcp/i/nursing-education-resources-for-program-directors-just-culture-information

NCBON Just Culture STUDENT PRACTICE EVENT EVALUATION TOOL (SPEET)

- http://www.ncbon.com/myfiles/downloads/just-culture-speet.pdf