2017 NCSBN Annual Institute of Regulatory Excellence (IRE) Conference - Errors of Omission: How Missed Nursing Care Imperils Patients Video Transcript
©2017 National Council of State Boards of Nursing, Inc.

Event
2017 NCSBN Annual Institute of Regulatory Excellence (IRE) Conference

More info: https://www.ncsbn.org/9913.htm

Presenter
Beatrice Kalisch, PhD, RN, FAAN, Professor, University of Michigan at Ann Arbor

- [Dr. Kalisch] I'm going to talk about research I've done over the past 10 years. Some of you may or may not remember that my first part of my career, I spent on the image of a nurse. This part has been on this missed nursing care and teamwork. So I'm going to review with you studies of missed nursing care, studies of nursing teamwork, studies of missed care and teamwork, and strategies to overcome missed care. Missed care is defined as any aspect of required patient care that is omitted or seriously delayed. They're errors of omission, as opposed to errors of commission. I got into this, because there's over 120 studies that show us that the level and type of nurse staffing results in certain patient outcomes. So I thought, "Well, what's going on in the middle, in the process, that leads to these results?" So that was my passion 10, 12 years ago. I developed this model, which I tested here. It's a structure, process, and outcome, standard model. On the structure side are hospital characteristics, such as the size, the teaching intensity, and whether they're magnet or not. Unit characteristics, I used Case Mix Index as a proxy for acuity, and we calculated on the patient unit level. Then, nurse staffing hours per patient day, RN hours per patient day, scale mix, type of nurse staffing, the education and experience, absenteeism, and work schedules. Then, teamwork is also, I put as a structure variable. How well do the nursing staff work together? I focused on the nursing staff, just because I can't study everything. I really believe that a lot of what happens or not is because the team works well together or doesn't. So that's how I came about that. Missed nursing care is the process variable in the middle, and the outcomes are both the staff and the patients. For the staff, it results in satisfaction, turnover, intent to leave. For patient outcomes, such things as falls, infections, pressure ulcers, readmissions, and so forth. So that gives you the overall scope of what this work is about. I started with the qualitative study, and I think I did 12 hospitals or something. I don't know. It's been so long, and I'm getting old. Don't tell anybody. Don't you love it when you walk up to somebody and you know them, and then you're just like, "It isn't going to come out when I have to introduce him to somebody else?" But I never could do that, so that makes me feel a little better. The qualitative study was a series of focus groups with nursing staff in different organizations. It turned out that there were nine areas of missed care that they identified, ambulation, turning, delayed or missed feedings, patient education, discharge planning, emotional support, hygiene, I&O, and surveillance. So then, I did a concept analysis. What is this missed care? So with one of my doctoral students, we developed... I'm not going to go into that. Then, the third thing, I said, "Well, we've got to have a way to measure this more broadly so we can see how extensive it is. Maybe it's just a phenomena in certain
hospitals." So we developed the MISSCARE Survey, and did the psychometrics, acceptability, validity, and reliability, and then administered it in a number of studies. People ask me for the tool all the time and I give it to them, and I just ask them, "Please send me the data, so I can enter it into the overall database and evaluate how well it's performing. I won't publish it or anything, but I just want to see that it's performing," and it is. It's amazing. Amazing how the same a level and type of missed care across hospitals. The first study I did was a three-hospital study, and it was in one system. It was one of my Ph.D. students, and she was the Corporate Director of Nursing and she wanted to do it, which was great. So we did the three-hospital study, and the research questions is, "What nursing care is missed? What are the reasons?" You have to do a lot of this work on the unit level, because a lot of the data, as you know, is reported at the unit level, the staffing levels, the adverse events, and so forth. In this study, we had 35 patient units. The response rate was 57%. We only surveyed RNs in this study, but we found a lot of missed care, and then they were the same across these three hospitals. Not the same, same, but awfully much alike. I said, "Well, how can this be?" I mean, I knew how this could be. "But do you call each other and ask, 'What are you going to miss?'" when I'd go back to give my reports on the results. So they were very simple and I thought, "It's maybe, just maybe, because they're in the same system." But it turns out, no. So I did another study of 11 hospitals with the same research question, "To what extent is nursing care missed? What's missed? How does this vary across hospitals?" The Part 2 of my survey is the reasons for missed care, and those too were very similar across the [[00:07:00]] initial three hospitals. "What are the reasons, and do they vary? Does missed care vary by staff characteristics?" The measures were the MISSCARE Survey, which I've already told you about. Then, I've been of passionate interest since I was a baby nurse, if I ever was, with nursing teamwork. So I developed a survey then to measure nursing teamwork, because I tried all the existing surveys and I couldn't get any variability. So this survey is really designed for inpatient nurses, although some people have tried to use it out in other settings, which is fine. Finally, I developed the MISSCARE Survey-Patient, because I said, "What can the patients tell us about what care they don't get?" So that's when I developed that survey. Then, I got administrative data from each of the units in the studies, turnover, HPPD, etc., the Case Mix Index, which I told you I used as a proxy for acuity, the average daily census, and then the adverse events. The study sample on the 11-hospital study was 124 patient care units in 11 hospitals, over 4,000 nursing staff. This time, I included the nursing assistants, and of course the LPNs. We don't have many, as you know, left. But this came out to be 980 NAs. The return rate, again, was 57%. You might wonder how I managed to get the same return rate. I turn upside down, jump. I put this giant candy bar in to induce guilt in every survey. I mean, giant. A lot of times, I go back to the hospitals, "Did you fill out my survey?" to the hospitals and they say, "I don't know." I say, "The one with the candy bar." "Oh, yeah." So I got their attention. Then, I gave a pizza party when they got up to 50% on their unit. So these were all incentives to help get the response rate to 57%, which if you know about surveys in nursing, is a pretty good number. The hospitals ranged from 60 to 913 beds. They were in Michigan and California. The study sample was over 35, 55%, 90% female, nursing education BSN or higher were 49%, experience greater than 5 years, half. Occupation, that means were they RN or were they NA? Three-fourths of them were RNs that responded. The employment status, we used this 30 hour a week in nursing to differentiate full and part-time, 82% were full-time, or 30 hours a week or more, and they worked the biggest number work, the day or the rotating shift. The five questions were, extent and type of missed care, do they vary across hospitals, what are the reasons, do the reasons vary, and how do RNs versus nursing assistants miss care? To what extent is it missed? This is the data, and it's more than you think. The number one missed care is ambulation, and it was 76% missed, and mouth care, 65%, medications on time, feeding patients when the food is still warm. People were telling me, "You wouldn't believe how many trays go back, where they haven't been touched by the patient." Back down to dietary, and there's a recent study out, and previous studies as well, that show that patients come into the hospital more nourished than when they leave. So that's another thing. Patient teaching, response to call light within five minutes, patient
bathing/skin care, and emotional support. Now, this is not all of the elements on the survey, but these were the ones that were missed the most. This graphic shows the most, again. Interdisciplinary care conferences or rounds ([00:11:30]) is something fairly new in our profession. But the studies are showing that it has a very positive effect on patient outcomes. At least in my hospital units, it was missed the most, and then mouth care, ambulation was one, excuse me, timely administration of medication, and turning. Then, the least missed is that ([00:12:00]) patient assessment the nurse does at the beginning of every shift. I asked them, "Well, what if you do the assessment and you can’t do the other work or the interventions that come from the assessment? Why?" We know why, because it’s reported, they have to document it, and it’s very visible. I want them to do that assessment, don’t get me wrong. But I’m just saying that they’re kind of crazy. Glucose monitoring, ([00:12:30]) discharge planning came up there as least missed. I don’t believe that. Later, I did the patient study and the patients said to me, "Nurses don’t do discharge planning." Of course, in my idealistic world, I [really fell off the chair]. Basically, the nurses said that it’s missed less, because they conceptualize discharge planning as that sheet of paper they take ([00:13:00]) in to the patient when the patient leaves, and tells them where to call and what medications to take. So you’ve got to understand what that means. Vital signs and focused reassessment. Does it vary across hospitals? The answer is no. This shows the variation, which is very little, on the most often missed. ([00:13:30]) One hospital, number eight, had a lower level of missed interdisciplinary care conferences, because they were really pushing it. This is the least missed, and you can see how consistent they are, as well. This is the same data in a different format. The black line in the middle of each of the bars is the variation and you can see, other than interdisciplinary care conferences, it’s a very ([00:14:00]) narrow variation. What are the reasons for missed nursing care? These were the three big buckets, or factors, that came out of my data, labor resources, material resources, communication, and teamwork. So I ran this data against how much missed care, and it didn’t turn out. I’m very disappointed. But it didn’t turn out, because there are a lot more reasons ([00:14:30]) than I have on my survey. I’m redoing the MISSCARE Survey Part 2 to try to capture more. But it’s so many little things, I think, that happen, that it’s hard to capture it completely. First of all, there’s interruptions and multitasking, and task switching. I did a study of this, and found that nurses are interrupted five times an hour on average, ([00:15:00]) and other studies have substantiated that. So that’s a lot of interruptions. We all know what happens to us, even when you’re young and vibrant, when you get interrupted. Right? "Where was I? Why am I here? What am I going to do?" Fatigue, the long work hours, the mandated overtime, we still see in many hospitals, the rotating shifts, lack of breaks. Nurses don’t like to take breaks. ([00:15:30]) Multiple jobs, about 5% have more than one job, according to the ANA. Moral distress, when they see that a patient needs a certain nursing intervention and they can’t do it for whatever reason, it causes what we call "moral distress" and that leads to fatigue. So they can see the patient needs to be ambulated, but they can’t get ([00:16:00]) to it for whatever reason, and then they result in... Nurses suffer a lot, as to what they get done and what they don’t get done. Burnout then, and then compassion fatigue. After a while, it’s like, "I can’t care anymore." Cognitive biases, the way we think. Omission bias, like if a nurse is looking at a patient that they know needs ambulation and they are ([00:16:30]) afraid the patient will fall unless they have enough people and equipment, they will just skip it. Because they’d rather omit something than do something that results in harm. It’s like the vaccinations. Mothers sometimes don’t get their kids vaccinated, because they are afraid of what will happen and don’t think about what the long run would happen. Then, there’s bandwagon. New ([00:17:00]) nurses come on the unit, they look around, and nobody else is ambulating patients or doing mouth care, or whatever. So after a while, they just, "I guess this is the way it is." That’s the status quo, too. Then, there’s complacency and habit. How are staff characteristics associated with missed nursing care? There’s no difference by gender and educational level. Under 35 reported less missed care. ([00:17:30]) The new nurse reports the least missed care, which I call it the "rose glasses phenomenon". They also report the best teamwork. So everything is looking good to them, because maybe they don’t know or maybe they chose this profession and they have to have it look good. So those with less than six months experience reported the least missed care. ([00:18:00]) Night shifts report less missed care and better teamwork. That's
Sometimes it's... Then, there's been a lot come out about mouth care recently. I don't know if you've noticed.

"They gave me a toothbrush and toothpaste when I came, and that's the last I heard about it. No one came and checked, or whatever."

Adults. They can take care of their own mouth," and the patients would say, "They reported. Mouthcare, they really value mouth care. I talk to the nurses and they say, "Well, the patient is an adult. They can take care of their own mouth," and the patients would say, "They gave me a toothbrush and toothpaste when I came, and that's the last I heard about it. No one came and checked, or whatever."

So sometimes it's... Then, there's been a lot come out about mouth care recently. I don't know if you've noticed.

©2017 National Council of State Boards of Nursing, Inc. All rights reserved.
Ambulation, getting out of bed into a chair, providing information about tests and procedures, and bathing. What difference does this make? Really, you have to step back on all of this, and I'm finding this missed care and I ask myself, "Well, what difference does it make?" I was at the Institute of Medicine for a year on a fellowship. That's where I got writing my book, and I spent the whole year going all over Washington, talking to people and trying to figure out why, and what we could do about it. Let's see. So one thing is it leads to more falls, I've found. Let me go to the next slide. You can see here, missed care mediates the relationship between staffing levels and fall rates. We've known that staffing levels result in more or less falls. But we haven't known why, again. Missed care, in particular, I think things like ambulation have resulted in more falls. Then, as I said, I combed the literature to find out what we know about the impact of various nursing interventions. We don't know as much as we should, by the way. I think many nurse researchers must look at this as less important than other evidence of research. Failure to ambulate, these are actual studies that I found the results. Nuance at delirium, pneumonia, delayed wound healing, pressure ulcers, increased length of stay, increased pain and discomfort, muscle wasting and fatigue, and physical disability, and it happens quickly, as you know. Failure to turn, pressure ulcers, pneumonia, venous stasis, thrombosis, embolism, stone formation, UTI, muscle wasting, bone demineralization, and atelectasis. Failure to administer medications, well this is hard to quantify, because it depends on what the medication is, as you know. But for C. diff, missing the first two doses of vancomycin is shown to increase the length of stay of those patients. Failure to do mouth care, which I think we've thought as really insignificant, has shown to cause a reluctance to eat. By the way, a study just came out that showed, you might have read, that... I've already said that, didn't I? The patients leave the hospital less nourished. Pressure ulcer development, pneumonia, particularly in ventilated patients, failure to teach, adverse events, readmission, which the hospitals get dinged for, as you know, in a major way. Failure to sleep results in mental impairment, susceptibility to infection, slow recover, and longer length of stay. Failure to wash their hands, CAUTIs, CLABSIs, and so forth, any infection. Failure to answer call lights, death, adverse events, falls, increased length of stay, increased pain and discomfort. Failure to eat, greater mortality, higher nursing home use, infections, increased length of stay, readmission, and higher costs. Failure to provide emotional support, patients really look to the nurse for safety, and I don't know how much we've really understood that. When the nurse is there, the patient feels much more safe than when they're not. Also, this results in a lack of hope. If the nurse isn't there with his or her emotional support, it really makes a difference and we haven't quantified that enough, in my opinion. Then, they can get distressed and agitated, and can't cope themselves. Failure for interdisciplinary rounds, which I've talked about earlier, can lead to adverse events, readmissions, catheters into lung, and high mortality. That's what the studies show us, and we need more. So on my survey of patients' missed care, I put a question in, "During this hospitalization, have any of these things happened?" I listed the adverse events that you see on the screen. What was interesting is that the more missed care they reported, the more likely they were to have these adverse events, skin breakdown/pressure ulcers, medication errors, new infections, falls, and of course IV issues, infiltration, and so forth. There's a guy at Yale, who I really like a lot. His name is Krumholz, and he wrote an editorial in the New England Journal of Medicine. It was called "Post-Hospital Syndrome", and we've known that in nursing. I mean, you can't ask a nurse who doesn't know, "What happens if a patient doesn't get ambulation?" How many of your friends or acquaintances have said, "The patient could walk in, but they had to go out with a wheelchair?" But he puts it so well. He's so articulate. "During hospitalization, patients are commonly deprived of sleep, experience disruption of normal circadian rhythms, are nourished poorly, have pain and discomfort, confront a baffling array of mentally challenging situations, receive medications that can alter cognition and physical function, and become deconditioned by bedrest or inactivity. Each of these trepidations can adversely affect the health and contribute to substantial impairments during the early recovery period, an inability to fend off disease, and susceptibility to mental error." Then, we wonder why post-admission problems occur. I think if we could do all the nursing care we know the patient needs, that would
seriously impact problems in a positive way, post-hospitalization. Okay, teamwork. Do nurse staffing levels predict nursing teamwork? Yes, they do. The fewer patients, the patient is taken care of, the higher the teamwork. When nurses evaluate the staffing... I had several measures of staffing in my study, by the way. "How many patients did you take care of in the last shift, and how do you evaluate the adequacy of staffing?"

Then, the actual HPPD and skill, now they all show that the more, the less. If that makes sense. The less they evaluated staffing as inadequate, the more the teamwork. Same with HPPD and skill mix were significantly associated with teamwork. So after controlling for CMI and bed size, the higher the HPPD, the higher the teamwork. The higher the skill mix, the higher the teamwork. The overall model accounted for 33% of the variation in teamwork. How does nursing teamwork vary with the size of the patient unit? I studied this with 2,053 units in four hospitals. The larger the unit, the less the nursing teamwork. If you look at some of the new hospitals, how big the units are... I was working with a hospital in Chicago, a children's hospital, and they said, "What are we going to do?" I mean, it was so big, they never run... Part of teamwork is just to accidentally run into each other. Well, they never ran into, they didn't even see each other. So we need to do our work with the hospital designers, and so forth. So this shows why. The red is RNs and the blue is nursing assistant. This is an analysis that we've collected the data on how many different people they work with in a given amount of time. You can see, it's enormous. They rarely see the same person twice, or work with the same person. So we need to redesign how we do this. Does nursing predict job... Oh, this is teamwork. Remember, I said that missed care predicted job satisfaction and occupation satisfaction? Well, so does teamwork. Why wouldn't it?

What's the first question I ask a group of nurses when I'm in their hospital? I studied this with 2,053 units in four hospitals. The larger the unit, the less the nursing teamwork. If you look at some of the new hospitals, how big the units are... I was working with a hospital in Chicago, a children's hospital, and they said, "What are we going to do?" I mean, it was so big, they never run... Part of teamwork is just to accidentally run into each other. Well, they never ran into, they didn't even see each other. So we need to do our work with the hospital designers, and so forth. So this shows why. The red is RNs and the blue is nursing assistant. This is an analysis that we've collected the data on how many different people they work with in a given amount of time. You can see, it's enormous. They rarely see the same person twice, or work with the same person. So we need to redesign how we do this. Does nursing predict job... Oh, this is teamwork. Remember, I said that missed care predicted job satisfaction and occupation satisfaction? Well, so does teamwork. Why wouldn't it?

What's the first question I ask a group of nurses when I'm in their hospital? I studied this with 2,053 units in four hospitals. The larger the unit, the less the nursing teamwork. If you look at some of the new hospitals, how big the units are... I was working with a hospital in Chicago, a children's hospital, and they said, "What are we going to do?" I mean, it was so big, they never run... Part of teamwork is just to accidentally run into each other. Well, they never ran into, they didn't even see each other. So we need to do our work with the hospital designers, and so forth. So this shows why. The red is RNs and the blue is nursing assistant. This is an analysis that we've collected the data on how many different people they work with in a given amount of time. You can see, it's enormous. They rarely see the same person twice, or work with the same person. So we need to redesign how we do this. Does nursing predict job... Oh, this is teamwork. Remember, I said that missed care predicted job satisfaction and occupation satisfaction? Well, so does teamwork. Why wouldn't it?

What's the first question I ask a group of nurses when I'm in their hospital? I studied this with 2,053 units in four hospitals. The larger the unit, the less the nursing teamwork. If you look at some of the new hospitals, how big the units are... I was working with a hospital in Chicago, a children's hospital, and they said, "What are we going to do?" I mean, it was so big, they never run... Part of teamwork is just to accidentally run into each other. Well, they never ran into, they didn't even see each other. So we need to do our work with the hospital designers, and so forth. So this shows why.
The ones that didn't work together, even though they were tired and they actually made more errors, but they caught each other's errors. You're familiar with the swiss cheese model, right? How people step in and catch other errors, which is what teamwork is about. I guess, I had the swiss cheese in there, but you know how this works. So I developed an intervention I call "teamwork tactics", and I tested it and it came out good, decreased missed care and increased teamwork. I developed these scenarios about what actually happens on patient care units. A patient needs a bedpan and asks the RN who's in the room for it. But instead of giving the patient the bedpan, they run all over the unit looking for the nursing assistant, because this is a nurse RN work. If I hear that RN versus NA work one more time I'll go crazy. The day shift does not do the patient's bath, and the night shift resents it, even though there may be very good reason. So I had these 22 scenarios like that and the trainees, they will play out these. I give them roles, or whoever is doing it gives them roles, like the RN 1 and the RN 2, and the nursing assistant, and whatever. They play it out, and then the group, which is usually five to six people analyze what happened. There's eight elements of teamwork that I work with, and maybe I'll get to that. Then, at the end of it, I said, "What care was missed because of teamwork problems?" So this is the results of that study, and there's other studies coming out of this, one out of Southern Indiana. So I think it works, because it's training the trainers. So you take three staff from every unit, you train them, and they stay on the unit so that they can be knowledgeable people. They can mentor. We take the trainers off for two days and train them. Then, they come back and train all their other colleagues in four one-hour sessions on the unit, because you can't get nurses off the unit. I mean, it's unbelievable how hard it is to educate nurses, compared to nuclear plants or whatever. But that's more important. Right? So it's three one-hour sessions, and then one follow-up six weeks later. So I got all this all packaged up, and the trainers do the scenario thing and roleplaying. It's good, because it's a higher level of engagement of the nursing staff, more personal involvement in their learning, and it took place in small groups. Because you can only get four to six staff members off the unit, even for an hour, as you know. Then, there's patient and family engagement, which has come about to be an important element. This is big. My studies in other countries showed that in places like China, they showed less missed care. Now, how could that be? Their staffing was so bad. Because the family comes in and does a big portion of the nursing care. Now, what do we do when family come around? Many times is we just want to get rid of them. They're too much trouble. So I think there are ways that we can engage the family. Liberal visitation, when I was a junior nurse, we wouldn't let patients' families it. It was a big deal. Interdisciplinary rounds at the bedside which include family members, permitting patients to read and write on their own chart. Oh, my gosh. They could read it? It's their chart, right? Change of shift report right at the patient bedside, so that the patient and family know what's going on. Putting patient advocates on care teams and counsels, and so forth. Technology can help us. I had a doctoral student who studied the impact of electronic reminders on missed nursing care, and found that it did reduce missed nursing care. So there's a lot of things we can do with technology. Symptoms [improver]. People are going to make mistakes. Care is going to be missed. It's that we never step back lately and say, "Why?" and try to figure out why. If we figured out why, we could intervene and change some of it. Then, emphasizing human factors, principles like reliance on memory, especially over 60, constraint, enforcing functions, all that. So design systems that are fault-tolerant, so that when an individual error occurs, it does not result in harm to a patient. Structured protocols, break in the link of chain that can lead to recurring problems, all the things you know about patient safety in general. Smaller units, space for communication, and I already told you the results of this study. I did four measures of unit size, and determined what level of teamwork resulted. In all four, there was a negative correlation between nursing teamwork and how many nursing aids there were, how much the average daily census was, and so forth. There were no significant relationships between teamwork and the number of RNs, or the number of staff overall, which is another
interesting finding. So we need to measure and measure often. It's the end. So I'd be happy to answer any questions I can now.

[00:43:59]
[no audio]

[00:44:05]
- [woman 1] Thank you, Dr. Kalisch. A question on the shift communication. Quickly, as I looked at the slide, did the nurses only interact with the nurses and the...
- Oh, thank you. Thank you. I didn't point that out. Nurses talk to nurses. Nursing aids report off to nursing assistants all over the United States. [00:44:30] Yeah. That's not a team. I mean, think about it. It's not a team. If the nurses are talking to each other and the nurse aids are talking to each other, and they never get together and plan the day, and decide what the priorities are, it's not a team. So yeah, that's what we found. Yes?
- [woman 2] Dr. Kalisch, pleasure to see you again. My very first nursing job many, many years ago was at Mott Children's Hospital. I don't expect you to remember me. But I [00:45:00] remember hearing you as a lecture.
- You know my memory.
- But I love your work, and I use this particular set of studies when I teach evidence-based practice to show kind of the same issue going from qualitative to quantitative, to interventional. So I particularly love this series of studies.
- Thank you.
- I have my own ideas. But I would kind of like your thoughts about extrapolating from teamwork in the hospital to what we do as [00:45:30] educators with students when we assign group projects. One of the acronyms that I've kind of used when I'm trying to use humor to get students to enjoy group work is TEAM, "Together, everybody achieves more." What students often learn is, "Together, everyone annoys me." Given that nursing education is the basis and we're sending people out, what thoughts do you have about [00:46:00] how you might extrapolate what you're doing with interventions in practice units to what we as educators can be doing with students in small groups of experiences, that you know both worlds.
- They need team training before they leave, and the team training that I do is to take specific elements of teamwork that you can feel and see, and touch. Is there leadership? Is there team orientation? [00:46:30] Are the team goals more important than the individual goals? So that when the nurses at the beginning of a shift spend I don't know how long saying, "Well, I got five patients and you have four. Why is that?" that arguing over how many patients not the workload, not, "We have nine patients together. We need to figure out how to get this done. Let's discuss that." [00:47:00] So that, and then a shared mental model, that they have the same mental model about what needs to get done and who needs to do it. Because if it's not clear, it creates problems. Then, there's closed-loop communication. When you can communicate an idea to somebody else and they can repeat it back to you, it's closed-loop. But as we know, a lot of communication isn't closed-loop. So if you practice it, [00:47:30] if you teach the students the importance of it, you can go a long way. Then, there's trust. Without trust, you don't have teamwork and all these other things lead up to trust or not. Anyway, I won't go...
- Thank you. That's exactly what I wanted to hear. One of the things we've started doing is, whenever we have small-group experiences, students have time to develop a process contract and a project management plan. So there's both task and process. Sometimes [00:48:00] we don't make the processes as visible as being equally important as the outcome.
- Right, and we don't tell them how to work together...
- Exactly.
- ...and don't tell them how to evaluate it.
- We just assume we put the groups, we convene groups...
- Now, go at it.
- ...and magic happens and it doesn't.
- Oh, I know. I know. "So and so didn't do their share."
- Thank you.
- "Well, did you talk to them about it?" "Well, no." You're right. I'm glad you're doing it.
- Thank you.
- [woman 3] Thank you [[00:48:30]] very much. I just have two quick things I wanted to mention. From the patient side of it, I can remember probably about 10 years ago, my husband's grandmother was admitted to a medical unit. I was a clinical nurse educator on that unit at that hospital, a relatively small hospital. She was in the early stages of Alzheimer's disease, and she was decompensating a bit, but she wasn't too bad. But they decided they needed to admit her. I, knowing the experience, thought, "I don't think that this is a particularly [[00:49:00]] good idea." I went in the next morning. She had gotten up in the middle of the night, had a fall. She had wondered into a MRSA-positive room, so now she was on precautions in her room, in a private room. I said to the nurse, "What's going on?" The nurse said to me, "It's my first day. I don't know." I was an educator who worked with these nurses. So it's really interesting to hear what you have to say, and I was really partway through the presentation wondering where patient rounds and reporting, [[00:49:30]] and if you measured that in missed care. Because that's [inaudible 00:49:33]...
- No, but I want one of you to do that.
- Yeah. Because I don't know if anyone else in the room has heard that, "But it's my first day. I don't know." It's not an acceptable answer, especially to a family member.
- Where's her mentor.
- Let alone, how are you going to provide care?
- Right. I agree.
- So I think that would be a really interesting area to look at.
- My study has shown that... I think I showed interdisciplinary rounds.
- Yes.
- That includes [[00:50:00]] nurse rounds result in better outcomes. So we know that. But there's a lot more research to be done. Anybody interested, I'll help you.
- My other comment was around the teamwork aspect of it. So I work in nursing regulation, and what we find is that when RNs and LPNs work together, they graduate, they go on to work on a unit, they have to rely on each other, but they don't understand each other's scope.
- Right.
- [[00:50:30]] They don't really understand how to work together.
- Oh, I know.
- Because they don't appreciate each other's scopes. So as a regulator, ourselves as well as the college-licensed practical nurses, have gotten together to do some education with those groups that are struggling and it's everything you said. It's about trust. It's about respect for each other's scope. So I think as regulators, that's an area that we can influence around patient safety.
- Yes. I've run into that a lot every time I do an assessment of a hospital, nursing organization. If there's LPNs and [[00:51:00]] nurses, and RNs, there's a lot of stress and pointing fingers, and...
- Sort of protection?
- Yeah.
- Yeah, for sure. Thank you very much.
- Yes?
- [Jan] Hi. I'm Jan Moseley from the Idaho State Board of Nursing, and just a couple quick questions also.
- Nice to meet you.
- You too. Great presentation. You've inspired me to try to impart this knowledge at my organization and with board members. But did you do any looking at the care delivery models [[00:51:30]] at the different
organizations, care pairs, teamwork, primary nursing, [inaudible 00:51:35]...
I've done that in relation to teamwork. When in interventions for teamwork, I've done things like take a 40-bed... Not me. But get the nurses on the unit, working with them, convincing them to do it, a 40-bed unit and divide into 4 10-bed units. That has really good results. Nurses don't want to do that. They don't want to work with the same 15 people. Because I put it so it was an around-the-clock team, so they'd look at themselves not just as a shift team, but around-the-clock team. So they report off to the same people, and so forth and so on. It works really well. I've done it in three or four hospitals now. But what the biggest obstacle in the beginning is, that the nursing staff don't want to work with those 15 people. That's the interesting thing. Now, why don't they want to work with the same people? Yes? Anybody? They're afraid of getting stuck with the poor performer.
- Got it.
- But the poor performer wouldn't be there, I mean, they would, if they dealt with it, if they gave them feedback. If they dealt with it, but, "No. It's Mama Manager. She has to do all that stuff." No. It's never going to happen like that. It's going to happen if each nurse... That's that teamwork stuff, giving feedback. I'll tell you, I spend a huge amount of time on how to give effective feedback in the Teamwork Tactics program. Because they don't know, they don't want to, they're afraid, and unless you can get feedback... "When you click that pen during report, I feel frustrated, because I can't concentrate on what people are saying. I would like you not to click the pen, and then I can concentrate. What do you think?" When you do it that way, what are you going to say? Do you think, "No? I want to continue to click the pen no matter what?" No. No. That's not going to happen. So I mean, it's a way that we haven't taught our nurses, nursing staff, how to really be effective in that.
- The other quicker one is, did you find some break point, as far as size of unit, when it was too big?
- I don't have a break point. But I can tell you that 20 beds is plenty big. That's what comes to mind when I think of those. I should have done that. I guess, I could go back and... Would you like to analyze the data? I'm looking for help. Do you get that impression? Anybody who'd like to analyze that data, I'll send it to you.
- [woman 4] I have a question for you. I really enjoy working in teams. But my question is, do you think teams are more effective when they're assigned, or when the RN decides to pick their own teams, versus just self-assigning?
- Well, if life were only so nice, right? The logistics of these things are what the problem is. They have to see the payoff in working with the same team effectively to make the sacrifices that they need to make to work with the same people. The problem is that people have schedules. What I build into these smaller teams is a relief team that can come in and give relief to people that aren't there. Do you know what I mean? So if somebody takes a vacation, there's somebody to fill in. It just...
- I just know, anecdotally, that when you do scheduling and stuff, it tends to work better if they self-schedule.
- The self-scheduling.
- Yeah. I'm wondering if you take that out to the floor nursing, if they were to make their own teams, if that would...
- Sometimes it would work and sometimes it wouldn't. But I wish it would work. I wish that life was like that. I wish. But see, then nobody wants to work with those few people that are problems. "So and so has an issue, an attitude." That's human. It's going to be there. Yes?
- [woman 5] I have a question about documentation. So we know that nurses are spending a lot of time in documentation. Did you look at documentation completeness at all?
- It's one of the elements of nursing care in the tool, and they miss that less. I don't remember what the number was, but it's not on that top.
- You include it wasn't in the top list.
- Right. Now, of course, that whole documentation thing is, as we all know, a huge issue. "Do you want me to do
the care, or do you want me to document it?"
- Right.
- The whole, "Well, I thought both, maybe." So the documentation is taking more and more time. Sorry to cut you off over there. Every time there's a problem, we come up with a new form, and they have to fill out a new form. I mean, we're going to get smart someday about the documentation issue. But it might not be in my lifetime.
- [woman 6] Dr. Kalisch, I thoroughly enjoyed your presentation.
- Okay. Where are you?
- She may not see me. I'm probably right...
- Actually. That was a brilliant presentation. I've worked in executive hospital administration, and it saddens me to think that after all these years, this continues. When the IOM report came out in the late '90s, many of these principles were identified there. It was the translation [inaudible 00:57:56]...
- Teamwork was.
- Well, the other observation I just want to share with you. I've been down to Quantico in Virginia, where they train law enforcement, and these principles are definitely part of their training in terms of teamwork, with squads and strategic tactics, and teamwork tactics. Maybe the urgency there is that if you don't work effectively as a team, you're probably going to harm yourself or someone else, and it's so crucial. I've always thought, "Why can't those types of lessons learned translate into..."
- They can and they have.
- Is there any model that you've looked to where other disciplines exhibit these behaviors beyond...
- Yes. I work with a guy right down here in Florida. His name is Silas [sp]. He's at the University of Central Florida in Orlando. He developed this model that I keep talking about with the eight elements of teamwork that you can see and feel, and touch. That's why I went with his theory, because to me it made the best sense, something people could understand and see. So yeah, it's the same. He's from the military.
- The military do it.
- The military has done a lot with it.
- I have two other comments. In terms of Never Events that came to the forefront for hospitals, in that you've not seen any impact from those types of initiatives, the Never Events or the National Quality Forum?
- Falls.
- Beyond falls.
- I showed you the falls.
- Yes.
- I haven't been able to do anything with pressure ulcers. I think the way we measure pressure ulcers is a problem. We do a prevalence. Are my answers too long? We do a prevalence. We go around saying on a given day, how many pressure ulcers there are. I don't think that's working, because I had friends at IQ that I called and I said, "What's going on here? I show that the more missed care..." Well, let's see if I can get this right. That was significant in the wrong direction. In other words... I won't be able to say it. Do you know what I mean? The more the missed care, the less the pressure ulcers, significantly less. It's just the opposite.
- Opposite.
- I thought, "Oh, my god. What's going on?" Well, I contacted other people and they've had the same problem. Let's see. I'm really good at this. The more the staffing, the more the pressure ulcers. So there's
something wrong with that. So other things would be readmission rate. I think somebody is looking at that. I get contacts from...
- The insurers are.
- What?
- The insurers are.
- Oh, yeah.
- Because you're not going to pay for it.
- Right. So some of the things have been shown, but not enough.
- If you could predict the future, in terms of...
- Is that all?
- ...the hospitals being [[01:01:00]] so very acute and length of stay having diminished, which probably has stabilized, do you see this problem continuing to worsen?
- If we don't get on top of it, and we don't look at it and examine it, and if every shift on, "What did we miss? Why?" if we don't... The other thing is, all the time, nurses say, they go, "We don't have enough staff. Top administrators [[01:01:30]] just shut us off." I mean, what do you mean you don't have enough? If you go, "Because we didn't have enough staff on a given blah, blah, these things didn't get done, and the results of not doing those things are," we would get a whole lot further. We need to do the research that shows, that's the most... I'm biased, I'm sure. But I think that's the most important research, that we have to show what happens. Nursing care is [[01:02:00]] so valuable and so incredibly cost-effective, and yet nurses themselves don't seem to know it or value it. "I'm just the nurse." We've really got to work on that, because "I'm just a nurse," "I'm a nurse, and this is what difference it makes when I can do the care and when I do, do the care, that I know the patient needs." But I mean, it's sort of like we got [[01:02:30]] into image, because nurses were not recognizing how important they were. Well, it's the truth with this too. Yes?
- [Tiffany] I'm Tiffany. I'm from the state of Michigan. Go blue, Michigan alumni.
- Yay. I said, "Where's Michigan?"
- Right here. I am a board member and I sit on the disciplinary subcommittee. That has been one of my big things is that we see these cases come in where nurses are being disciplined for [[01:03:00]] some of the things that are pretty trivial, if you look at the whole scope of things. I've been trying to get the board and people that do the investigations to do some data collection on, "What were the numbers? How many patients were they caring for?" Some kind of data, just so we can have a database to give some of this information on what is causing these little things to happen. I think it's an excellent opportu-....
- What little things?
- Anything that they're being disciplined for.
- Oh.
- Because we get all the cases.
- Yeah. I see very trivial things, like a nurse missed giving a Maalox or something, and they were fired and the case went to the board.
- Well, that's going to get us nowhere.
- Exactly. So I think it's an excellent opportunity for the state boards of nursing to collect data on why these nurses are being disciplined. And what kind of patient load did they have at that point in [[01:04:00]] time, and see if there's any correlation between what they're being disciplined for and what the staffing was at that time. So you get these reports? I'm [inaudible 01:04:11]...
- Yeah. I sit on the disciplinary subcommittee. So anything that they feel is a patient safety issue, or whenever a nurse gets fired from a hospital, it gets reported to the Board of Nursing. The board does an investigation, they see if it's worthy of a discipline, and then it comes [[01:04:30]] to the disciplinary subcommittee, where we
review the cases. Then, we sanction the license based on what is presented to us.
- But the emphasis would be errors of commission, right?
- A lot of them, yes.
- I don’t know what to say, but it sounds like an important area.
- Yeah.
- Does anybody else here have thoughts about that?
- [woman 7] [inaudible 01:04:53]
- Who’s talking?
- [inaudible 01:04:58]
- [Maryann] [01:05:00] Dr. Kalisch, I’m Maryann Alexander. I’m the Chief Officer of Nursing Regulation at NCSBN. We actually do have a study that looks at errors that boards submit and we’re able to analyze. It’s called "TERCAP". Right now, we’re going to be in the process of revising some of those questions, because it’s been in process now for about 10 years, and we want to update it. So [01:05:30] we would welcome suggestions and what you think need to be in it. But we also welcome all the boards to participate and we’d love to share some of the data with you.
- Oh, I would love to see that. That’s very interesting. Thank you. Is that the last question?
- [woman 8] Okay, it’s time for a break now, so be back at 2:15. Thanks. Thank you, Dr. Kalisch.